STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065393	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Aurora	1800 S Potomac St Aurora, CO 80012

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 50853

Based on record review and interviews, the facility failed to develop a comprehensive care plan for services that were provided in order to to attain the resident's highest practicable physical, mental, and psychosocial well-being and to provide effective and person-centered care for three (#4, #11 and #26) of 13 residents out of 37 sample residents.

Specifically, the facility failed to:

-Ensure the comprehensive care plan addressed Resident #4's pressure ulcer;

-Ensure the comprehensive care plan addressed Resident #11's changes related to her feeding tube, diet, intravenous (IV) antibiotics and fall interventions; and,

-Ensure the comprehensive care plan addressed Resident #26's pressure ulcer.

Findings include:

I. Facility policy and procedure

The Care Planning policy, undated, was provided by the nursing home administrator (NHA) on [DATE] at 9:16 a.m. It read in pertinent part,

The facility will develop a comprehensive person-centered care plan following the most current regulatory requirements available. The care plan should be based on patient strengths and preferences, be oriented toward avoiding preventable declines in functioning, and reflect current standards of care in professional practice.

The care plan should be evaluated to determine if current interventions are being followed and if they are effective in attaining identified goals and the care plan should be modified as needed. Subsequent adjustment of interventions will depend on progress, underlying causes and overall condition. Modify the current care plan and add new or additional interventions as needed.

II. Resident #4

A. Resident status

(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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NAME OF PROVIDER OR SUPPLIER: Advanced Health Care of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE: 1800 S Potomac St Aurora, CO 80012	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4, age above 65, was admitted on [DATE] and discharged on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included chronic kidney disease, osteoarthritis (degenerative joint disease), glaucoma (chronic eye disease causing damage to the optic nerve and vision loss), and right knee effusion (fluid buildup and swelling). The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #4 was dependent on staff for transfers, required substantial assistance with bed mobility and used a wheelchair for mobility with substantial assistance from staff. She had one unstageable pressure injury present on admission. B. Resident interview Resident #4 was interviewed on [DATE] 3:36 p.m. She said she had a wound on her right heel and she wore a soft heel protecting boot when she was in bed. C. Record review The skin integrity care plan, initiated [DATE], indicated Resident #4 had a deep tissue injury to her left buttock and a stage one pressure injury to her spine. Interventions included notifying the provider of any changes, offloading the area as tolerated, completing weekly skin checks, and providing supplements, medications and treatments as ordered. The skin assessment note, dated [DATE], revealed Resident #4 had a deep tissue injury to her right heel. -Review of the comprehensive care plan did not reveal the care plan had been updated to indicate that Resident #4 had a deep tissue injury to her right heel. -The care plan did not include the intervention of the soft heel protecting boot (see interviews below). D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 9:14 a.m. LPN #1 said Resident #4 had a wound on her right heel and wore a soft boot for protection while in bed. The director of rehabilitation (DOR) was interviewed on [DATE] at 10:25 a.m. The DOR said she provided the soft heel protector for Resident #4 to wear while in bed or when up in her wheelchair when requested. The infection preventionist (IP) #2 was interviewed on [DATE] at 8:19 a.m. IP #2 said she was the wound care nurse. She said the pressure injury should have been included in Resident #4's care plan and the soft heel protector listed as an intervention. III. Resident #11 A. Resident status (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #11, age 85, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included sepsis (extreme reaction to an infection), acute respiratory failure with hypoxia (low oxygen in the body), chronic obstructive pulmonary disease (a common lung disease causing difficulty breathing), pneumonia, congestive heart failure (chronic condition when the heart cannot pump enough blood to the body), dysphagia (difficulty swallowing), asthma (inflammation an tightening of airway muscles causing difficulty breathing) and glaucoma (high eye pressure).

The [DATE] MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of eight out of 15. Resident #11 was dependent on staff for all activities of daily living (ADLs).

The MDS assessment indicated the resident was receiving all nutrition, liquids and medication through a feeding tube and was receiving intravenous (IV) antibiotics.

B. Resident interview

Resident #11 was interviewed on [DATE] 2:46 p.m. Resident #11 said she had made a significant improvement since her admission. She said she was eating orally now and no longer needed the feeding tube. She said her IVs were stopped. She said she had a fall at the facility where she sustained facial injuries. She said she did not recall any interventions the facility implemented after the fall.

C. Record review

The feeding tube care plan, initiated on [DATE], included interventions to aspirate the feeding tube for residual prior to feeding, confirm placement of the tube by inserting a small amount of air prior to feeding, elevate the head of the bed during feedings and 30 minutes after, administer feeding solution per physician order and administer medication per tube.

A review of the [DATE] physician orders revealed the resident's diet order was strict NPO (nothing by mouth).

A review of the September physician orders revealed the resident began taking food by mouth on [DATE]. A pureed diet for lunch and dinner was ordered on [DATE].

A minced and moist diet was ordered on [DATE] for all three meals.

The physician progress note dated [DATE] revealed the feeding tube was discontinued on [DATE].

-The comprehensive care plan was not revised to indicate Resident #11 was taking food by mouth, the feeding tube was discontinued or what type of diet was ordered.

The IV antibiotic care plan, initiated on [DATE], included interventions to keep the IV site patent and free of infection, change tubing and caps per protocol, perform dressing changes and site care per protocol, flush per protocol and administer medication as ordered.

A review of the September physician orders revealed the IV antibiotics were discontinued on [DATE].

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The comprehensive care plan was not revised to indicate the resident was no longer receiving IV antibiotics. The nursing progress notes indicated Resident #11 had an unwitnessed fall on [DATE]. A review of the post fall IDT progress note dated [DATE] revealed a non-skid surface to Resident #11's wheelchair was implemented for fall prevention. The note indicated the care plan was updated. -However, the fall care plan was not updated to include the recent fall or the new intervention of the non-skid surface in the wheelchair. D. Staff interviews Certified nurse aide (CNA) #5 was interviewed on [DATE] at 10:00 a.m. CNA #5 said she did not think Resident #11 was a fall risk. CNA #5 said the resident had one fall but had improved since then. CNA #5 said she was not aware of any fall prevention interventions that were implemented after the fall. The registered dietitian (RD) was interviewed on [DATE] at 2:50 p.m. The RD said when there was a diet change the nutrition care plan should be updated with the diet order and interventions. The RD said she put her updates in the nutrition assessment section. She said the nutrition team meeting notes were sent to the MDS coordinator so they could update the comprehensive care plan. The director of nursing (DON) was interviewed on [DATE] 11:14 a.m. The DON said fall interventions should be listed on the care plan. The DON Resident #11's feeding tube and IV antibiotic care plans should have been resolved and her nutrition care plan updated. IV. Resident #26 A. Resident status Resident #26, age 97, was admitted on [DATE] and expired on [DATE]. According to the [DATE] CPO, diagnoses included congestive heart failure, hypertensive heart disease, major depressive disorder, polycythemia vera (blood cancer causing bone marrow to produce too many red blood cells) and encephalopathy (unspecified condition causing brain dysfunction). The [DATE] MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of four out of 15. Resident #26 required substantial assistance from staff for all ADLs. B. Record review The baseline care plan, dated [DATE], documented the resident had a pressure injury on the sacrum (the bone at the base of the spine above the coccyx). The comprehensive care plan, skin section, initiated on [DATE], indicated Resident #26 had an alteration in skin integrity consisting of blanchable red (redness of skin that temporarily disappears with light pressure) ears and coccyx. Interventions included notifying the provider of any changes, offloading the area as tolerated, completing weekly skin checks and providing supplements, medications and treatments as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The comprehensive care plan did not indicate the presence of a pressure injury to the sacrum. The [DATE] wound physician (WP) note revealed Resident #26 had a stage IV pressure injury to the sacrum. The WP provided treatment orders and instructed staff to turn the resident from side to side in bed every one to two hours. -The comprehensive care plan was not updated to include the stage IV pressure injury and did not include the WP's treatment orders or recommendation for turning. C. Staff interviews The DON was interviewed on [DATE] 11:14 a.m. The DON said each discipline updated their own section of the care plan. The DON said care plans should be updated when there were any changes in a resident's care. The DON said the pressure injury should have been included in Resident #26's comprehensive care plan.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48458 Based on observations, record review, and interviews, the facility failed to ensure proper storage of medications in the medication storage room and in one of three medication storage carts. Specifically, the facility failed to: -Discard medications from the medication cart that had been discontinued; -Remove loose pills from drawer of a medication cart; and, -Ensure the temperature of the medication refrigerator was assessed, documented and addressed as needed. Findings include: I. Facility policy and procedure The Medication Storage policy, revised September 2021, was provided by the nursing home administrator (NHA) on 10/21/24 at 6:06 p.m. The policy, in pertinent part, contained the following information: -Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. All drugs and biologicals are in locked compartments under proper temperature controls. Medications requiring refrigeration, or temperatures between 36 degrees and 45 degrees Fahrenheit (F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Refrigerator temperatures are monitored twice daily and recorded in the Refrigerator Temperature Log Book. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists. II. Observations and interviews On 10/21/24 at 10:18 a.m. the medication storage cart in hall #1 was observed with licensed practical nurse (LPN) # 1. The following was observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An open Fluticasone and Salmeterol 232 microgram (mcg)/14 mcg inhaler labeled with Resident #11's name. LPN #1 said the medication had been discontinued on 8/13/24 and should have been discarded after the physician's order was discontinued. -Four loose pills were in the bottom of the second drawer of the medication cart. LPN #1 said the loose pills needed to be discarded and was unsure of what the pills were. On 10/21/24 at 10:40 a.m. the medication storage room was observed with registered nurse (RN) #1. The following was observed: The August 2024 (8/1/24 to 8/31/24) medication refrigerator temperature log was missing documentation that indicated the temperature was taken on 13 days (8/11, 8/12, 8/13, 8/17, 8/18, 8/19, 8/20, 8/21, 8/25, 8/26, 8/27, 8/28 and 8/31/24). The medication refrigerator temperature was documented on 8/15/24 as 48.2 degrees F. The medication refrigerator temperature was documented on 8/16/24 as 51.6 degrees F. -There were no documented interventions for the temperature readings above 46 degrees F. The September 2024 (9/1/24 to 9/30/24) medication temperature log was missing documentation that indicated the temperature was taken on 17 days (9/2, 9/3, 9/4, 9/8, 9/9, 9/10, 9/11, 9/15, 9/16, 9/17, 9/18, 9/23, 9/24, 9/25, 9/28, 9/29 and 9/30). The October 2024 (10/1/24 to 10/21/24) medication temperature log was missing documentation that indicated the temperature was taken on 14 days (10/1, 10/2, 10/7, 10/8, 10/9, 10/12, 10/13, 10/14, 10/15, 10/16, 10/18, 10/19, 10/20 and 10/21). RN #1 said the temperatures should be checked and logged each day. RN #1 said the temperatures on 8/15/24 and 8/16/24 were abnormal. She said there was not a way to know the medication refrigerator temperature on the days that was no documentation. RN #1 said the nurses were responsible for checking the temperatures. She said she had noticed the weekend nurses had not been documenting them. III. Additional staff interviews The director of nursing (DON) was interviewed on 10/21/24 at 4:40 p.m. The DON said medications should be removed from the medication cart on the same day they were discontinued. The DON said the medication refrigerator temperatures should be checked daily and abnormal temperatures reported and addressed. IV. Facility follow up On 10/24/24 at 7:27 a.m. the DON provided a staff education document titled Medication Storage Policy and Procedure/ Medication Room/Both Refrigerator Temperatures. The education contained 10 staff signatures and was dated 10/22/24 (during the survey). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The education content included a review and copy of the entire medication storage policy and stated expectation for staff to check refrigerator temperature every shift and document the temperature readings in the temperature book and to remove medications from the medication cart within 24 hours of discontinued physician order. The DON also provided a new form titled medication room temperature log which had entries for twice daily monitoring of medication refrigerator temperatures, with the normal ranges included. The form also had a statement, If temperature outside approved ranges, must notify DON and maintenance.

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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 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.

Specifically, the facility failed to:

-Ensure the residents were offered hand hygiene before meals in the dining room and during the delivery of room trays; and,

-Ensure point of care (POC) testing supplies were not contaminated from room to room.

Findings include:

I. Failed to ensure hand hygiene was offered to residents prior to meals

A. Professional reference

According to the Centers for Disease Control and Prevention's (CDC) Hand Hygiene in Healthcare settings, revised 2/27/24, was retrieved on 10/28/24 from https://www.cdc.gov/handhygiene/index.html Patients and visitors should clean their hands before preparing or eating food. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics, and protects healthcare personnel and patients. Using an alcohol-based hand sanitizer is the preferred way for you to keep your hands clean.

B. Facility policy and procedure

The Dining Experience policy, revised January 2021, was provided by the nursing home administrator (NHA) on 10/22/24 at 4:16 p.m. It read in pertinent part, Individuals will be provided with proper hand hygiene prior to each meal or snack, prepared for the meal by the nursing staff (hearing aids in place, dentures in, hair combed, dressed properly, and eyeglasses on); and assisted to the dining area as needed.

C. Observations

On 10/21/24 during a continuous observation, beginning at 11:40 a.m. and ending at 1:20 p.m., residents arrived for lunch in the main dining room, some walking in, some self-propelling themselves in manual wheelchairs and some escorted in by staff.

Resident #13, #22, #44 and #65 in wheelchairs were handling the large wheel on their manual wheelchairs to propel themselves into the dining room. Residents were assisted to sit at their tables by staff in the dining room. Tables in the dining room had multiple residents sitting together. Of all the residents in the dining room (28 total residents), none were offered or assisted with hand hygiene.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 12:46 p.m., CNA #1 delivered a room tray to room [ROOM NUMBER]. At 12:47 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 12:48 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 12:50 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 12:51 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 12:53 p.m. a meal tray was delivered to room [ROOM NUMBER]. -There were no individual hand sanitizing packets on the room trays and CNA #1 did not ask, encourage or assist any of the residents with washing or sanitizing their hands before the meal.Additional meal tray observations: On 10/21/24 at 12:48 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 12:49 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 12:51 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 1:00 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 1:01 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 1:02 p.m. a meal tray was delivered to room [ROOM NUMBER]. At 1:06 p.m. a meal tray was delivered to room [ROOM NUMBER]. -Staff did not encourage or assist residents with hand hygiene. D. Resident interviews Resident #49 was interviewed on 10/21/24 at 11:59 a.m. Resident #49 said the staff had never offered hand sanitizer or to wash his hands in the dining room. Resident #7 was interviewed on 10/21/24 at 1:20 p.m. Resident #7 said the staff did not offer hand hygiene prior to her meal on this day (10/21/24). E. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 10/21/24 at 1:06 p.m. CNA #1 said she had not offered hand hygiene to the residents who ate independently during the lunch meal. CNA #2 was interviewed on 10/21/24 at 1:11 p.m. CNA #2 said he did not offer hand hygiene to any residents in the dining room prior to the lunch meal. He said all residents should be offered hand hygiene prior to meals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 10/21/24 at 4:42 p.m. The DON said hand hygiene should be offered to residents prior to meals in the dining room or the resident rooms, regardless of whether the resident was independent with self-care. II. Failed to ensure point of care testing supply was not contaminated A. Professional reference According to Agency for Healthcare Research and Quality's Clean Equipment and Environment Promotes Safe Resident Care, revised March 2017, was retrived on 10/28/24 from https://www.ahrq.gov/hai/quality/tools/cauti-ltc/modules/implementation/education-bundles/infection-prevention/environment-and-equipment/environ-equip-slides.htmlInfectious agents, like bacteria or viruses can move from one person to the next and possibly spread throughout an entire facility. They are transmitted by our hands, a contaminated surface or a piece of equipment that is used between residents. B. Observations On 10/23/24 at 11:52 a.m. licensed practical nurse (LPN) #2 placed blood sugar testing supplies which included test strips, lancets and alcohol wipes in a disposable plastic 120 milliliter (ml) cup. LPN #2 brought the cup to room [ROOM NUMBER] and placed it on the resident's dining table. LPN #2 then used supplies from the cup to test the resident's blood sugar. At 12:08 p.m. LPN #2 brought the same disposable cup with remaining testing supplies from room [ROOM NUMBER] to room [ROOM NUMBER] and placed the cup on the resident's dining table. She used the supplies from the cup to test the resident's blood sugar. At 12:18 p.m. LPN #2 placed the disposable cup with remaining supplies in the top drawer of the hall #3 medication cart. At 12:24 p.m. LPN #2 removed the disposable cup from the top drawer of the hall #3 medication cart and used the remaining supplies to test Resident #65's blood sugar while he was sitting in the hallway. C. Staff interviews LPN #2 was interviewed on 10/23/24 at 12:08 p.m. LPN #2 said she should not have brought the disposable plastic cup with testing supplies from room to room and back to the medication cart as this could spread infection. The DON was interviewed on 10/23/24 at 12:45 p.m. The DON said LPN #2 should have brought enough testing supplies for each individual resident to each resident. The DON said it was inappropriate to use the disposable cup with testing supplies for multiple rooms/residents as it was an infection risk. D. Facility follow up (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 1:26 p.m. the DON provided documentation for education provided to LPN #2 which included the requirement to utilize POC supplies for one resident (not sharing supplies for multiple residents).