

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Suites at Holly Creek Care Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 5590 E Peakview Ave Centennial, CO 80121	

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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315</p> <p>Based on observations, record review and interviews, the facility failed to ensure one (#6) of one resident reviewed for pressure injuries out of 20 sample residents received care consistent with professional standards of practice to prevent and heal pressure injuries.</p> <p>Resident #6 was admitted on [DATE] for long term care. At the time of admission, the resident was identified for being at risk for developing pressure injuries. Upon admission, the resident had a surgical incision on her right leg and her skin was otherwise intact. Resident #6 attended dialysis three times a week.</p> <p>On 8/2/24, a primary care physician documented Resident #6 developed a blister on her left heel that had thick white drainage which may have represented some early infection. Preventative measures to protect the resident's heels were not implemented until after the development of the blister on 8/2/24.</p> <p>On 9/6/24, a physician's progress note documented the resident's left heel had developed eschar (dead tissue). On 11/7/24, when the wound care physician took over care (three months after the blister was initially identified), the wound was classified as an unstageable ulcer to the left heel.</p> <p>Due to the facility's failure to implement effective pressure injury interventions in a timely manner, Resident #6 developed a facility-acquired unstageable pressure injury to her left heel.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved on 11/24/24 from https://www.internationalguideline.com/guideline,</p> <p>Pressure ulcer classification is as follows:</p> <p>Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage)</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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).</p> <p>Category/Stage 2: Partial Thickness Skin Loss</p> <p>Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.</p> <p>Category/Stage 3: Full Thickness Skin Loss</p> <p>Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.</p> <p>Category/Stage 4: Full Thickness Tissue Loss</p> <p>Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable</p> <p>Unstageable: Depth Unknown</p> <p>Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.</p> <p>Suspected Deep Tissue Injury: Depth Unknown</p> <p>Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>II. Facility policy and procedure</p> <p>The Pressure Injury Prevention and Management policy and procedure, revised November 2022, was received from</p> <p>the nursing home administrator (NHA) on 11/21/24 at 2:46 p.m. It documented in pertinent part, The purpose of the policy is to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries. Preventative interventions can be, but are not limited to, frequent position changing and support of pressure points, adequate hydration and nutrition, appropriate exercise and movement, frequent perineal care, proper lifting techniques, correct application of pressure relieving devices and frequent inspection and assessment of skin integrity.</p> <p>Compliance with interventions will be documented in the medical record. The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. A key implementation to pressure ulcer management will be interdisciplinary team (IDT) involvement and review and comprehensive care planning.</p> <p>III. Resident #6</p> <p>A. Resident status</p> <p>Resident #6, age 73, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included diabetes mellitus (high blood sugar), end stage kidney disease (kidneys can no longer support body's needs) with hemodialysis (process where a machine filters and cleans the body's blood), right below the knee amputation and peripheral vascular disease (narrow blood vessels).</p> <p>According to the 10/19/24 minimum data set (MDS) assessment, Resident #6 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required substantial/maximal assistance for showering/bathing, dressing and transferring. She was independent with wheeling in her motorized wheelchair.</p> <p>The MDS assessment documented that the resident was at risk of developing pressure ulcers and had one unstageable pressure ulcer due to the coverage of the wound bed by slough (soft, dead tissue, usually cream or yellow in color) and/or eschar.</p> <p>B. Resident interview</p> <p>Resident #6 was interviewed on 11/18/24 at 2:53 p.m. Resident #6 said the wound to her left heel developed at the facility and the facility staff were not floating the heel or using the blue booties prior to it developing. She said the heel wound started as a blister.</p> <p>C. Wound observation and interview</p> <p>On 11/20/24 at 2:10 p.m., a wound observation was completed with the assistant director of nursing (ADON). Resident #6 was positioned in her motorized wheelchair. The resident was wearing a soft blue bootie on her left foot.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>With consent from the resident, the ADON removed the dressing to the resident's left heel. Moderate light brown drainage was observed on the dressing. The wound on the resident's heel was round in shape, covering the entire heel. The wound was covered in black tissue (eschar), obstructing the wound. The periwound (skin surrounding the wound) was red.</p> <p>The ADON said there was stable eschar covering the wound. She said the periwound was red. She said there was little to no drainage. She said she had been tracking the wound since it started as a blister. She said at first it was cellulitis and the resident was started on an antibiotic.</p> <p>D. Record review</p> <p>The admission Braden scale for predicting pressure sore risk was completed on 7/15/24. It documented Resident #6 had a score of 18 which indicated she was at risk for developing pressure ulcers due to being chairfast, having slightly limited mobility, not having adequate nutrition and a potential problem for friction and shear.</p> <p>The skin integrity care plan, initiated 6/12/24 and revised 8/30/24, identified the resident had actual impairment to skin integrity with a right below the knee amputation and a left heel open blister. The care plan documented Resident #6 chose to remain in her wheelchair for long periods of time despite the potential risk of skin breakdown attributed to prolonged immobility (added 8/30/24). Interventions included cellulitis identified with pitting edema causing a blister. Treatment initiated. Prevelon boot (soft blue boot) ordered for offloading therapy (initiated 8/2/24), avoiding scratching and keeping hands moist and keeping fingernails short, educating caregivers and the resident of causative factors and measures to prevent skin injury (initiated 6/21/24), following facility protocols for treatment (initiated 8/13/24), using booties at night for skin integrity (initiated 8/6/24), providing a pressure-redistributing bed with a pump to prevent pressure ulcers due to her immobility (initiated 8/30/24) and monitoring/documenting location, size and treatment of skin injury and reporting abnormalities, failure to heal, signs and symptoms of infection or maceration to the physician (initiated 6/21/24).</p> <p>Review of Resident #6's November 2024 CPO revealed a physician's order to float the resident's heel when in bed, ordered 8/2/24.</p> <p>-However, review of the resident's August 2024 treatment administration record (TAR) revealed there was no documentation of the left heel being offloaded until 8/6/24, four days after the wound was identified and the above physician's order was obtained.</p> <p>A note from the vascular surgeon on 9/30/24 documented a follow up appointment Resident #6's left heel wound. The note documented the resident had adequate blood flow to her left lower leg.</p> <p>The wound care physician's (WCP) progress note from 11/21/24 documented Resident #6's left heel wound was an unstageable pressure wound due to necrosis (dead tissue). It was documented that there was moderate serous exudate (clear to light yellow fluid leaking from the wound) with 90% thick adherent devitalized necrotic tissue and 10% slough (shedding).</p> <p>IV. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Certified nurse assistant (CNA) #4 was interviewed on 11/20/24 at 2:30 p.m. CNA #4 said Resident #6 had a wound to her left heel. She said she required one staff member's assistance for dressing, bathing and transferring with a slide board. She said on the days the resident went to dialysis, she required two people for assistance because staff used the hooyer lift so she had a sling under her body for transferring at dialysis. CNA #4 said Resident #6 never refused care.</p> <p>The director of nursing (DON), the ADON and the NHA were interviewed on 11/20/24 at 3:00 p.m. The DON said Resident #6 was readmitted on [DATE] after a right below the knee amputation. She said the resident was weight-bearing as tolerated and working with therapy. She said the resident scored a mild risk for pressure injury development on her admission Braden scale, so additional interventions were not put into place. She said on the Braden scale from 7/29/24, she scored a moderate risk so an intervention for a wheelchair cushion was added to help prevent pressure injury to her bottom.</p> <p>The DON said Resident #6's left heel blister was identified on 8/2/24 and a Prevelon boot (protective boot) was ordered. She said there was an order to offload the resident's heel until the boot came in on 8/6/24. She said the boot was not appropriate for the resident prior to the development of the wound because she was working with therapy and was weight-bearing as tolerated. She said she was wearing a regular shoe prior to the development of the heel blister. The DON said once the eschar formed on the wound and it was deteriorating, a pressure-reducing mattress was ordered on 8/30/24. The DON said Resident #6's vascular surgeon and the resident's primary care physician were managing the left heel wound initially. She said the WCP began to manage the wound on 11/7/24 (three months after the development of the wound).</p> <p>The WCP was interviewed on 11/21/24 at 12:00 p.m. The WCP said Resident #6's left heel wound was an unstageable ulcer with 100% necrotic eschar that had been stable for the past three weeks, since she had taken over her wound care management. She said the first week, on 11/7/24, when she saw Resident #6, there was no drainage to the wound. She said on 11/21/24 there was moderate serous drainage.</p> <p>The WCP said since the wound had deteriorated, she did a small debridement on 11/21/24 and talked to Resident #6 about ordering a different style of boot that would offer more protection to the heel. She said the wound was caused by pressure between the foot and the bed or chair. She said the resident had multiple comorbid factors which included diabetes type two, peripheral vascular disease and neuropathy that were likely all contributing factors to the development of the wound. She said offloading the heel was always a beneficial intervention for pressure injury prevention.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262</p> <p>Based on observations, record review and interviews, the facility failed to ensure two (#4 and #10) of two of 20 sample residents remained free from accidents hazards.</p> <p>Specifically, the facility failed to ensure Resident #4 and Resident #10 had a physician's order, a consent and a completed safety assessment before the implementation of a floor to ceiling transfer pole by the resident's bed.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Bed Mobility Devices policy, approved October 2024, was provided by the nursing home administrator (NHA) on 11/20/24 at 10:30 a.m. The policy revealed bed mobility devices had the potential to cause actual harm or entrapment to residents. The facility would follow the recommendations and guidelines as outlined to ensure resident safety and the appropriate use of the devices. Residents considered for a bed mobility device must be evaluated by physical therapy for safety and benefit. This therapy evaluation included an evaluation for safety as well as a discussion of the risk versus the benefits waiver and a consent. The safety evaluation included the resident's physical ability, cognition and ability to understand the education.</p> <p>II. Resident #4</p> <p>A. Resident status</p> <p>Resident #4, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included dementia, muscle weakness, atrial flutter (fast heart rate), abnormalities of gait and mobility.</p> <p>The 8/17/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. The resident required partial/moderate staff assistance to sit to stand (ability to come to a standing position from sitting in a chair, wheelchair or on the side of a bed) and chair/bed to chair transfer (ability to transfer to and from a bed to a chair or a wheelchair).</p> <p>B. Resident observations</p> <p>On 11/18/24 at 12:34 p.m. a floor to ceiling transfer pole was observed beside the resident's bed and near the resident's recliner. The resident was sitting in a recliner across from the bed.</p> <p>On 11/19/24 at 1:39 p.m, a floor to ceiling transfer pole was observed beside the resident's bed and near the resident's recliner. The resident was sitting in a recliner across from the bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/20/24 at 12:50 p.m., a floor to ceiling transfer pole was observed beside the resident's bed and near the resident's recliner. The resident was sitting in a recliner across from the bed. The transfer pole by the bed measured eight inches away from the bed frame, toward the center of the room.</p> <p>C. Record review</p> <p>A fall risk assessment dated [DATE] at 11:37 p.m. revealed a score of 12.5 which indicated the resident was a high fall risk.</p> <p>The care plan for activities of daily living (ADL) self-care performance deficit was revised on 4/30/24. The pertinent interventions included providing extensive staff assistance for transfers. One staff member was to provide assistance to move the resident between surfaces. The resident had a transfer bar (pole) located adjacent to the bed and recliner.</p> <p>A review of the resident's electronic medical record (EMR) on 11/20/24 did not reveal a physician's order for the use of a transfer pole, the assessment or the consent.</p> <p>III. Resident #11</p> <p>A. Resident status</p> <p>Resident #11, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included diaphragmatic hernia, retention of urine, long term use of an anticoagulant and an acute embolism and thrombosis of the deep veins of the left lower extremity.</p> <p>The 11/2/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required substantial/maximal staff assistance to sit to stand and chair/bed to chair transfer.</p> <p>B. Resident observations and interview</p> <p>On 11/18/24 at 12:51 p.m. a floor to ceiling transfer pole was observed beside the resident's bed and a second transfer pole was near the resident's recliner.</p> <p>On 11/19/24 at 11:17 a.m. a floor to ceiling transfer pole was observed beside the resident's bed and a second transfer pole was near the resident's recliner. The resident was sitting in the recliner and said he used both transfer poles to help him stand up.</p> <p>On 11/20/24 at 12:40 p.m. a floor to ceiling transfer pole was observed beside the resident's bed and a second transfer pole was near the resident's recliner. The resident was sitting in the recliner. The transfer pole by the bed measured five inches away from the bed frame, toward the center of the room.</p> <p>C. Record review</p> <p>A fall risk assessment, dated 11/1/24 at 2:54 p.m., revealed a score of 10.5 which indicated the resident was at high fall risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The care plan for ADLs self-care performance deficit was revised on 7/31/24. The pertinent interventions included the resident required extensive staff assistance for transfers. Two staff were to provide assistance to move the resident between surfaces.</p> <p>-The care plan did not reveal the resident utilized transfer poles.</p> <p>A review of the resident's EMR on 11/20/24 did not reveal a physician's order for the use of a transfer pole, the assessment or the consent.</p> <p>IV. Staff interviews</p> <p>The director of rehabilitation (DOR) was interviewed on 11/20/24 at 2:03 p.m. The DOR said there was no official transfer pole assessment for either resident, prior to the installation of the transfer poles. She said the transfer poles would be placed by each resident's bed frame so that the pole could be used by the resident to assist with transfers and a sufficient distance from the bed frame so that entrapment did not occur.</p> <p>The NHA and the director of nursing (DON) were interviewed on 11/21/24 at 11:40 a.m. The NHA said Resident #4 was a high fall risk. The NHA said the resident had no falls nor any injuries related to the use of a transfer pole. The NHA said that physical therapy did not do an official transfer pole assessment prior to the installation of either of the transfer poles in the resident's room on 10/14/24. The NHA said the ability or the functionality of each resident, determined the distance the transfer pole was positioned adjacent to the bed frame. The NHA said the resident's beds were always in a locked position and the relative distance to the transfer pole remained the same. The NHA said the physician's order and consent for the transfer poles were obtained on 11/19/24 (during the survey). The NHA said the resident's transfer pole assessment was completed by physical therapy services on 11/20/24 (during the survey). The NHA said the sequence for the use of a transfer pole was to obtain a physician's order, complete the safety assessment, obtain a consent from the resident or their legal representative and then the installation of the device.</p> <p>The NHA and the DON were interviewed together on 11/21/24 at 12:06 p.m. The NHA said Resident #11 had good cognition and good upper body strength. She said the resident used the transfer poles and had not had any issues with them. The NHA said the physician's order and consent for the transfer poles were obtained on 11/19/24(during the survey). The NHA said the resident's transfer pole assessment was completed on 11/20/24 (during the survey).</p> <p>V. Additional provided documents (during survey)</p> <p>A physician's order dated 11/19/24 at 5:57 p.m. (during the survey) revealed to place a transfer pole next to Resident #4 and Resident #10's bed and recliner. The staff were to check the placement and secure the transfer poles. The staff were to notify environmental services if the devices needed adjustments for every day and night shift for mobility.</p> <p>A Transfer Pole consent and release form was signed by the Resident #4 and Resident #10 on 11/19/24 (during the survey).</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315</p> <p>Based on observations 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:</p> <ul style="list-style-type: none"> -Ensure staff donned (put on) appropriate personal protective equipment (PPE) when providing care to a resident on enhanced barrier precautions (EBP); and, -Ensure staff followed appropriate infection control practices while cleaning resident rooms. <p>Findings include:</p> <p>I. Failure to ensure staff donned appropriate PPE when providing care to a resident on EBP</p> <p>A. Professional reference</p> <p>According to the Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQs) About Enhanced Barrier Precautions (EBP) In Nursing Homes (6/28/24) retrieved on 11/12/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html,</p> <p>EBP are an infection control strategy that involves wearing gowns and gloves during high-contact resident care activities. Enhanced Barrier Precautions are recommended for residents with any of the following: infection or colonization, or a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a multi drug resistant organism (MDRO).</p> <p>B. Facility policy and procedure</p> <p>The Enhanced Barrier precautions policy and procedure, revised July 2024, was received from the nursing home administrator (NHA) on 11/20/24 at 12:50 p.m. It documented in pertinent part, EBP are an infection control intervention designed to reduce the transmission of resident organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds, indwelling medical devices and infection or colonization with a multi-drug resistant organism. Examples of high contact resident care activities requiring gown and gloves use for EBP include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care and wound care.</p> <p>C. Observations</p> <p>On 11/20/24 at 9:20 a.m., certified nursing assistant (CNA) #2 was completing catheter care for Resident #20. The sign on the cabinet in the resident's room indicated the resident was on EBP and the required PPE included wearing gloves and a protective gown when performing high contact direct resident care. CNA #2 washed her hands, applied clean gloves and proceeded to complete catheter care for the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Suites at Holly Creek Care Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 5590 E Peakview Ave Centennial, CO 80121	

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

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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>-CNA #2 did not put a protective gown on prior to entering Resident #20's room and performing catheter care.</p> <p>D. Staff interviews</p> <p>CNA #4 was interviewed on 11/20/24 at 2:30 p.m. CNA #4 said when she was providing care to residents with catheters, she would wear gloves for any care she provided. She said she would only wear a gown if the resident was on contact precautions.</p> <p>The infection preventionist (IP) was interviewed on 11/21/24 at 11:50 a.m. She said chronic wounds, foley catheter, and any open lines qualified a resident to be placed on EBP. She said CNA #4 should have followed the appropriate PPE recommendations and donned a gown prior to performing catheter care for Resident #20.</p> <p>II. Failure to ensure staff followed appropriate infection control practices while cleaning resident rooms</p> <p>A. Professional reference</p> <p>According to the CDC Recommendations for Hand Hygiene for Healthcare Workers, (2024), retrieved on 11/26/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, CDC provides the following recommendations for hand hygiene in healthcare settings. Know when to clean your hands: after touching a patient's surroundings, immediately after gloves removal.</p> <p>B. Facility policy and procedure</p> <p>The Hand Hygiene policy and procedure, revised November 2022, was received from the regional director of clinical services (RDCS) on 11/21/24 at 12:17 p.m. It documented in pertinent part, the community considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene includes both hand washing and the use of alcohol-based hand sanitizer. The use of gloves does not replace hand hygiene.</p> <p>C. Observations</p> <p>During a continuous observations on 11/20/24, beginning at 8:20 a.m. and ending at 9:15 a.m., the following was observed:</p> <p>Housekeeper (HSKP) #2 was observed cleaning resident room [ROOM NUMBER]. She donned clean gloves and sprayed down all high touch surfaces. She removed the gloves and without sanitizing her hands, donned clean gloves. She wiped down all the surfaces in the bedroom and bathroom and sprayed the shower with water. She removed her gloves and without sanitizing her hands, donned clean gloves. She swept the bathroom and entry way and mopped the bathroom and entry way. She dusted the shelves, vacuumed the bedroom and changed the trash. She removed her gloves and without sanitizing her hands, donned clean gloves. She moved her cart down the hall.</p> <p>HSKP #1 was observed cleaning resident room [ROOM NUMBER]. She was in the middle of cleaning with just mopping left to complete. She removed her gloves and without sanitizing her hands, donned clean gloves. She mopped the bathroom and entry way.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Suites at Holly Creek Care Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 5590 E Peakview Ave Centennial, CO 80121	

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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>D. Staff interviews</p> <p>The IP was interviewed on 11/21/24 at 11:50 a.m. The IP said the staff should complete hand hygiene to be completed prior to and after glove removal.</p> <p>The environmental services coordinator (ESC) and the RDCS were interviewed together on 11/21/24 at 11:45 a.m. The ESC said the expectation for housekeepers cleaning resident rooms was to change gloves between cleaning each room, which included the kitchen, bedroom and bathroom. She said there would be at least three gloves changes and she would expect hands to be sanitized after each glove removal.</p>