STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065408	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Villa	1625 Simms St Lakewood, CO 80215

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on interviews and record review, the facility failed to protect and keep residents safe from physical abuse for one (#37) of three residents reviewed for physical abuse out of 29 sample residents. Specifically, the facility failed to protect Resident #37 from physical abuse by a staff member. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy and procedure, revised September 2022, was received from the nursing home administrator (NHA) on 12/23/24 at 11:00 a. m. It revealed in pertinent part, If resident abuse, neglect, exploitation, misappropriation or resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Upon receiving any allegation of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) were needed for the protection of the residents. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. If the investigation reveals that the allegations of abuse were found, the employee(s) is terminated. II. Incident of physical abuse The facility investigation of the incident involving Resident #37 revealed the following: (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/16/24, an agency certified nurse aide (CNA) called the director of nursing (DON) and informed her she did not like how staff were treating residents and she would not be returning to the facility. The DON called the agency registered nurse (RN), who was working the night of 11/16/24 to get more information on the situation. The agency RN told the DON that the agency CNA was making negative remarks about the facility and the CNA was afraid Resident #37 would harm her. The agency RN told the DON Resident #37 had an increase in behaviors, along with exit seeking, during the evening and was placed on a one-to-one with a staff member. There were no further concerns reported to the DON regarding staff treating residents poorly. On 11/18/24 the nursing home administrator (NHA) and the DON reviewed security footage of the facility, per the usual routine, and identified an incident, on video surveillance, that occurred between Resident #37 and the agency RN. Video surveillance revealed the agency RN swinging her arm and knocking the resident's cup of water out of his hand and then she continued to push Resident #37, causing him to stumble backwards and lose his footing. The DON conducted an assessment on 11/18/24 of Resident #37 which concluded no injuries were noted to the resident. Resident #37 was interviewed but due to his level of cognition, he was unable to recall the event or provide information on what occurred. The facility identified Resident #37 was at his baseline for behaviors and exit seeking. The alleged assailant (agency RN) was interviewed on 11/18/24 by the DON and the NHA. The agency RN was shocked to hear she had pushed and hit Resident #37. The RN said the incident had only been a reaction and was not intentional. The facility investigation concluded that abuse did occur between the agency RN and Resident #37. The agency RN was not allowed to return to the facility and she was reported to the state board of nursing. The facility notified Resident #37's physician, the resident's representative and the local police department of the abuse. The incident was reported to the state occurrence website. An all staff meeting was conducted on 11/19/24 where the NHA reviewed appropriate interactions with residents and how they should be treated with dignity and respect. The NHA also reviewed the proper way to provide touch assistance. The NHA reviewed with all staff that it was never appropriate to put hands on a resident and if someone was experiencing behaviors that could not be redirected, it was best to give the resident some space and clear the area where the resident could de-escalate away from staff and other residents. III. Resident #37 A. Resident status Resident #37, age greater than 65, was admitted [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbances, chronic obstructive pulmonary disease (COPD - an abnormal exchange of oxygen in the lungs) and depression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/20/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. He required partial assistance from staff for dressing. He required set up assistance for eating and personal hygiene. He was independent with transfers and ambulation. The assessment documented the resident did not reject care assistance and was not physically aggressive towards others. B. Resident representative interview Resident #37's representative was interviewed on 12/16/24 at 2:28 p.m. The representative said the facility had contacted her in November 2024 about an incident where Resident #37 and a staff member were pushing each other. She said the staff member had been terminated by the facility and Resident #37 had no injuries from the incident. C. Record review The comprehensive care plan, initiated 9/18/24, documented Resident #37 had a behavior problem. He could be verbal with staff and other residents when sundowning. He could become agitated and physical with staff. He had a history of calling staff racial slurs during care or when they were attempting to redirect him. Interventions included allowing the resident to de-escalate in a calm area, providing activities of interest to the resident, explaining all care to the resident prior to initiating care to allow the resident to adjust to changes, offering snack preferences of chips and 7-Up, taking the resident for walks in the afternoon hours and monitoring the resident's hours of sleep. A behavior progress note, dated 11/16/24 at 6:06 a.m., documented Resident #37 was agitated and attempted to throw heavy objects at the nurse, along with exit-seeking and setting off the alarms on exit doors. A behavior note, dated 11/16/24 at 2:30 p.m., documented Resident #37 was exit-seeking. The resident was redirectable and given a task to complete. A behavior note, dated 11/16/24 at 10:10 p.m., documented Resident #37 had been exit-seeking with multiple attempts to redirect him. The resident was agitated and wanted to exit the alarmed doors. Resident #37 was mumbling as he approached the nurse who was at her medication cart preparing medications and the resident attempted to pour water on the nurse's head. The nurse put up her arm to stop the resident's advancement and the water from being poured. Resident #37 walked into the nurse's arm and stumbled off balance. The nurse documented the resident said he was sick of being told what to do. A CNA assisted the resident to his room in an attempt to calm him down with fewer people around to decrease the risk of negative interactions with other residents. Another resident was yelling at Resident #37 to not hit women. Resident #37 told the other resident to shut up. A CNA attempted to sit in Resident #37's room with him for safety but Resident #37 continued to exit-seek and became agitated. The CNA and the nurse attempted to change Resident #37's clothing due to it being soiled but he refused. Resident #37 became combative and attempted to trip and kick the nurse. A behavior note dated 11/17/24 at 12:00 a.m., documented direct care assignment of Resident #37 was directed to another licensed nurse with on- to-one CNA monitoring for safety and wellness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note, dated 11/17/24 a 5:32 p.m., documented Resident #37 had been on one-to-one supervision at all times to maintain safety and prevent exit-seeking actions. Resident #37 was provided with various chores and tasks to keep him occupied and reduce agitation. A behavior note, dated 11/18/24 at 3:52 a.m., documented there was no physical aggression against staff noted. Resident #37 continued to exit-seek with increased agitation due to his inability to successfully and independently exit the facility. Resident #37 randomly sat and slept for short periods of time and then woke up to start pacing/exit seeking. IV. Staff interviews The DON was interviewed on 12/19/24 at 10:20a.m. She said abuse allegations were to be reported to the NHA immediately for further investigation. The DON said she received a call from an agency CNA on the night of 11/16/24. She said the agency CNA said she wanted to be removed from the schedule because she did not want to work in a place where the residents were not treated right. The DON said the agency CNA hung up on her before giving her any details regarding what she was referring to. The DON said she made several attempts to get in touch with the agency CNA after she hung up on her but the CNA did not answer her calls. The DON said once she was able to finally get ahold of the agency CNA again, she said the CNA told her she did not like how a resident was taken to their room by two staff members and then she stopped answering questions. The DON said the agency CNA would not give her any details about why she had concerns. The DON said after she talked to the agency CNA the second time, she called the facility and spoke with the RN assigned to the front unit to try to figure out why the CNA said she did not want to work at the facility. The DON said the agency RN informed her she was unable to find the agency CNA in the building and she was not aware of any concerns involving residents and staff. The DON said she interviewed all staff in the building via telephone on 11/16/24 and did not find any concerns with staff not treating residents correctly. She said she called the NHA to inform her of the concern and her findings on the night of the incident. The NHA was interviewed on 12/19/24 at 11:53 a.m. The NHA said she was the abuse coordinator for the facility and any reports of abuse were to be called to her attention 24-hours a day/seven days a week. She said the facility educated staff on what abuse was on hire and at all staff meetings. The NHA said she directed staff to report anything they might suspect was abuse. She said even if staff had doubts about whether abuse actually occurred, they should report it. The NHA said she was notified by the DON on 11/16/24 about an agency staff CNA who called and said she would not be returning to the facility due to how a resident was treated. The NHA said the DON interviewed all staff members, via telephone, who were working in the facility on 11/16/24 about concerns voiced by the agency CNA. The NHA said none of the staff members reported any concerns to the DON on the night of 11/16/24. The NHA said the agency RN completed her scheduled shifts on 11/16/24 and 11/17/24 because the initial interviews conducted by the DON on 11/16/24 did not lead the facility to believe abuse had occurred, as none of the staff interviewed voiced any concerns (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said when she came into the facility on the following Monday (11/18/24), she reviewed the video surveillance of the facility from the weekend, as was her usual practice. The NHA said when she was going through the surveillance footage from the weekend, she saw an incident between Resident #37 and the agency RN the DON had spoken to on the night of 11/16/24. The NHA said the video footage revealed that Resident #37 walked up to the agency RN from behind with a cup of water and when the RN turned around, she swatted the cup out of the resident's hand. The NHA said the footage further revealed the agency RN pushed the resident backwards with one hand. The NHA said the video had voice recording and the agency RN was heard yelling stop, I didn't do anything to you. The NHA said Resident #37 was observed stumbling backwards and losing his balance but the NHA said the resident did not fall. The NHA said, after viewing the video footage and seeing what occurred between Resident #37 and the agency RN, she began an investigation into the incident. She said the facility attempted to interview Resident #37 about the incident, but she said based on his cognitive status, he was unable to recall the incident. She said the DON conducted a skin assessment on the resident and no injuries were noted. The NHA said she substantiated that abuse had occurred based on the video footage. The NHA said the physician, responsible party and the police were all notified of the occurrence on 11/18/24. The NHA said she reported the incident to the State Agency and the agency RN was reported to the agency company she worked for and to the state board of nursing. The NHA said the agency RN had been offered a position in the facility full-time prior to the incident, but the offer had been rescinded due to the abuse observed in the video surveillance. The NHA said the facility verified that all agency staff received education for abuse and dementia training from their respective agencies prior to working in the facility.

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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** 40960 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 development and transmission of diseases and infection. Specifically, the facility failed to: -Ensure housekeeping staff followed proper cleaning techniques for cleaning and disinfecting resident rooms and high frequency touched areas (call lights, door handles and handrails); -Ensure housekeeping staff used the correct surface disinfectant products; -Ensure enhanced barrier precautions (EBP) were in place for a resident with a stage IV pressure injury prior to wound care; and, -Ensure washing machine temperatures were checked daily and lint traps were emptied timely. Findings include: I. Housekeeping A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 12/21/24 from https.//pubmed.ncbi.nlm.nih.gov. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease). Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stays, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 12/21/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/pre ent/resource-limited/cleaning-procedures. html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques. It read in pertinent part, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. B. Facility policy and procedure The Daily Room Cleaning policy, undated, was provided by the nursing home administrator (NHA) on 12/19/24 at 1:19 p.m. It read in pertinent part, Throughout the cleaning process, you must be thorough as germs are everywhere. In corners, small openings, grooves, and the underside of objects. Dip the cleaning cloth into the disinfectant and hand wring. Wipe the headboard, the bed controls and the foot board. Disinfect the night stand top, the sides, the front, the back and the legs. Wipe the telephone paying close attention to the receiver. Clean the over bed table and clean it thoroughly, working from the upper surfaces to the lower surfaces. Wipe clean the pedestal, base and the casters. Disinfect the toilet bowls, flush before cleaning. Apply toilet bowl cleaner and disinfectant to the inside of the toilet. Clean the rim, spray the outside and bottom surfaces with disinfectant solution and wipe and spray the toilet seat with the disinfectant. Spray a small amount of cleaner in the sink and rub the cleaner around the top and inside of the sink. Wipe the sink and the top dry. Dampen a cloth in disinfectant and wipe the counter top, being careful to clean under personal items left by the resident. Clean under the personal items left by the resident. Clean under the items and place them back in a neat arrangement. Clean the counter front, inside sink doors, the piping, and all exposed surfaces of the entire unit. Use pre-measured disinfectant floor cleaning chemicals for mopping. Before leaving the room, inspect the room according to the checklist and to make sure all required cleaning tasks were performed. C. Observations During a continuous observation on 12/18/24 at 10:06 a.m. housekeeper (HSK) #1 was observed cleaning room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HSK #1 pushed the cleaning cart to the door way of room [ROOM NUMBER]. She donned (put on) gloves and removed a disinfectant spray bottle and the toilet brush from the cart. She entered room [ROOM NUMBER]'s bathroom. She sprayed the inside of the toilet bowl and scrubbed it with the toilet brush. She placed the toilet brush back into the cart and removed her gloves. She used hand sanitizer and put on clean gloves. She removed a small container of a soap solution and a scrubbing pad. She washed the inside of the sink. She placed the container with the scrub pad back into the cart. She removed the broom and swept the room. She placed the broom and dust pan back onto the cart and removed a green rag. She placed the green rag on the sink and splashed water onto the mirror. She used a paper towel from the dispenser to wash the mirror. She turned on the sink and wet the green rag. She wiped out the inside of the sink, the top of the sink and the faucet. -HSK #1 did not use a disinfectant while cleaning the sink. HSK #1 washed her hands and donned clean gloves and removed the disinfectant spray bottle and a green rag from the cart. She sprayed the toilet. She used the green rag to wipe the seat of the toilet, the rim, the toilet seat a second time, the back of the seat, the side of the toilet, the front of the toilet tank and the top of the tank. She sprayed the two grab bars, on each side of the toilet, with the disinfectant spray and used the same rag to clean the grab bars. She placed the spray bottle and rag back onto the cart. She removed her gloves, used hand sanitizer, and donned clean gloves. She removed a mop pad from the water bucket and sprayed it with a cleaner. She dropped the mop pad on the floor and placed the mop handle on top. She mopped the room first and then the bathroom. She pushed the cleaning cart to room [ROOM NUMBER]. -HSK #1 failed to use the correct cleaning techniques to clean the toilet and the grab bars. -HSK #1 said there was no disinfectant in the mop pad bucket and it only contained plain water. -HSK #1 did not disinfect high touch areas such as the door knobs, light switches, call light and bed controller. HSK #1 used hand sanitizer and donned gloves and entered room [ROOM NUMBER]. She removed the container of a soap solution and a scrubbing pad and washed the inside of the sink. She returned the container to the cart and removed the disinfectant spray. She sprayed the leather recliner and used a green rag to wipe it down. She placed the soiled rag on the cart. She removed a clean green rag from the cart and walked to the sink. She used her gloved hand to splash water onto the mirror. She wiped it dry with a paper towel. She sprayed disinfectant onto the rag and wiped the top of both of the night stands. She placed the soiled rag on the cart and removed the broom. She then swept the room. She placed the broom back on the cart and removed a mop pad from the water bucket. She sprayed the mop pad with cleaner and mopped the bedroom floor. The bathroom was shared with room [ROOM NUMBER]. She pushed the cleaning cart to room [ROOM NUMBER]. -HSK #1 said there was no disinfectant in the mop pad bucket and it only contained plain water. -HSK #1 did not disinfect high touch areas such as the door knobs, light switches, call light and bed controller. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The housekeeping and laundry manager (HLM) was interviewed on 12/18/24 at 11:09 a.m. The HLM said a multipurpose cleaner should have been used for the cleaning of the floors. He said there was a chemical dispensing system in the janitor closet. He said when the HSK filled the mop bucket they should have pushed the button on the dispenser to add the cleaner to the water. He said the cleaner spray was only used to give the room a clean smell and did not disinfect. He said the toilet brush should never be used outside of the toilet bowl. He said the toilet should be cleaned with a disinfectant and wiped with a clean rag from top to bottom. He said high touch surfaces should be disinfected daily as well as the sink and any frequently touched surfaces. He said HSK #1 should not have cleaned the grab bars after the toilet with the same rag. He said the toilet should always be cleaned last. He said HSK #1 should have thrown the comb and tooth paste in the trash so it could not be used. He said he would reeducate HSK #1 on the room cleaning process and procedures. The infection preventionist (IP) was interviewed on 12/19/24 at 10:47 a.m. The IP said a resident's room should be cleaned from top to bottom and cleanest to dirtiest. She said the bathroom should always be cleaned last. She said the grab bars should have been cleaned prior to the toilet. She said the toilet should be cleaned from top to bottom and the toilet bowl last. She said the toilet brush should only be used inside the toilet. She said a disinfectant should have been used to clean the sink, high touch surfaces and when mopping the floor. She said if items were on the floor, they should have been thrown away. She said she would immediately reeducate the housekeeping staff on the correct room cleaning process and the use of the correct cleaning chemicals. II. Enhanced barrier precautions A. Facility policy and procedure The Enhanced Barrier Precautions policy, revised March 2024, was provided by the NHA on 12/19/24 at 1:19 p.m. It read in pertinent part, Enhanced barrier precautions were utilized to reduce the transmission of multi-drug resistant organisms (MRDOs) to residents. Gown and glove use in addition to standard precautions should be used during high contact resident care activities when contact precautions do not apply. High-contact resident care activities requiring the use of gown and gloves for EBPs include dressing, bathing, transferring, changing linen, changing brief or toileting, device care and wound care. EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MRDO colonization. Wounds generally include chronic wounds such as pressure ulcers, diabetic foot ulcers, venous stasis ulcers and unhealed surgical wounds. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms. Residents, families and visitors are notified of the implementation of EBPs throughout the facility. B. Observations (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065408	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Villa	1625 Simms St Lakewood, CO 80215

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/24 at 12:19 p.m. Resident #35 was laying in bed waiting for the wound physician to perform wound care. The wound care physician and registered nurse (RN) #1 used hand sanitizer and donned gloves. They entered Resident #35's room and began her wound care. -The facility failed to identify the need for Resident #35 to be placed on EBPs for her chronic stage IV pressure injury. C. Staff interviews RN #1 was interviewed on 12/18/24 at 1:43 p.m. RN #1 said he was not sure what enhanced barrier precautions were or when they should be put into place. The director of nursing (DON) was interviewed on 12/18/24 at 1:44 p.m. The DON said there were no residents in the facility, at the time of the survey, that required EBPs. She said she would check to see if any residents needed to be on EBP. When she returned, she said Resident #35 should have been placed on EBPs and was not sure why she was not. She said she would immediately get a physician's order and place Resident #35 on EBPs. She said when a resident was on EBP the staff needed to wear a gown, gloves and mask prior to completing wound care. III. Laundry A. Facility policy and procedure The Soiled Laundry and Bedding policy, revised September 2022, was provided by the nursing home administrator (NHA) on 12/19/24 at 1:19 p.m. It read in pertinent part: Laundry equipment (washing machines and dryers) are used and maintained according to the manufacturer's instructions for use to prevent microbial contamination of the system. Laundry processed in hot water temperatures is 160 degrees F (fahrenheit) for 25 minutes. Laundry that is not hot water compatible, low temperature washing at 71 degrees to 77 degrees F (22-25 degrees celcius) plus chlorine or oxygen-activated bleach can reduce microbial contamination. The Cleaning Lint in Laundry policy, undated, was provided by the NHA on 12/19/24 at 1:19 p.m. It read in pertinent part: The policy statement was to maintain a safe, efficient, and sanitary laundry environment, lint must be regularly cleaned from laundry machines, lint traps, and surrounding areas. THis reduces the risk of fire, ensures proper machine function and maintains hygiene standards in the facility. The purpose was to establish a consistent procedure for cleaning lint in laundry facilities to promote safety, improve equipment performance and ensure compliance with applicable regulations. Remove the lint trap from the machine carefully after every load of laundry. Use a lint brush or hand to remove accumulated lint. Place the lint into a designated trash receptacle. Inspect the lint trap for tears or damage. Report any issues to the supervisor immediately. Maintain a log of daily, weekly, and monthly lint cleaning activities. Note any issues, repairs, or maintenance required in the log. B. Observations (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065408	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Villa	1625 Simms St Lakewood, CO 80215

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The laundry room was observed on 12/18/24 at 2:34 p.m. There were two washing machines. C. Record review A request was made for the temperature log for the washing machines. The facility was unable to provide a temperature log for the two washing machines. D. Staff interviews The HLM was interviewed on 12/18/24 at 2:34 p.m. He said he did not know he needed to check the temperature on the washing machines. The regional director of plant operations (RDPO) was interviewed on 12/18/24 at 10:47 a.m. He said the washing machine temperatures should reach 160F and tested daily with a thermometer to disinfect the laundry properly. The IP was interviewed on 12/19/24 at 10:47 a.m. The IP said she did not know how often the washing machine temperatures should be checked or what the temperature should be at.