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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review and interviews, the facility failed to ensure that its medication error rate was less than five percent (%). Specifically, the facility had a medication error rate of 6.45%, which was two errors out of 31 opportunities for error. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed., E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. According to the Instructions for use Humalin R KwikPen, retrieved on 11/23/24 from: https://pi.lilly.com/ca/humulin-n-r-ca-ifu-kp.pdf It revealed in pertinent Priming your pen. Prime before injections. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensure the pen is working correctly. If you do not prime the pen before injections, you may get too much or too little insulin. According to the How to Use Voltaren Gel instructions, retrieved on 12/23/24 from: https://www.voltarengel.com/arthritis-pain-gel/ It reveled in pertinent part Dosage: using the dosing care, apply the following amounts: Upper body areas (hand, wrist, elbow: 2.25 inches. Lower body areas (foot ankle, knee): 4.5 inches (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Facility policy and procedure The Administering Medications policy and procedure, revised April 2019, was received from the nursing home administrator (NHA) on 12/19/24 at 1:29 p.m. It revealed in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. The individual administering medications checks the label three times to verify the right resident, right medication, right dose, right time, and right method (route) of administration before giving the medications. III. Observations On 12/17/24 at 11:40 a.m. registered nurse (RN) #1 was administering medications for Resident #3. The medication ordered was Humalin R U-500 Kwik pen 500 units/milliliter (ml) inject 125 units subcutaneously before meals for diabetes. RN #1 collected the Humalin R pen from the medication cart, applied a new needle to the tip and dialed the insulin pen to 125 units. RN #1 then identified Resident #3, applied gloves, cleansed the site with an alcohol swab and administered the injection via pen into the resident's right lower abdomen. -RN #1 failed to prime the insulin pen for the correct dose of medications (see professional reference above). On 12/19/24 at 8:27 a.m. RN #1 was administering medications for Resident #10. The medication ordered was Volataren arthritis pain external gel one percent, apply to the right hip topically three times a day for osteoarthritis. RN #1 obtained a tube of Voltaren gel one percent from the treatment cart. He opened the tube and poured out about a quarter in diameter gel directly into a medication cup. RN #1 then identified Resident #10 applied gloves and applied the gel to the resident's right hip. -RN #1 failed to identify the medication order did not have a dose indicated (see professional reference above) in order to administer the correct dose to the resident. IV. Staff interviews RN #1 was interviewed on 12/17/24 at 12:41 p.m. RN #1 said insulin vials needed to be cleansed with an alcohol swab prior to inserting a needle to draw up the insulin. RN #1 was not aware he needed to cleanse the top of the insulin pen prior to applying the needle. RN #1 said he was did not know he needed to prime an insulin pen before dialing to the ordered dose. RN #1 said priming would waste the insulin. RN #1 said he would need to find out what the facility protocol on insulin pens was. Licensed practical nurse (LPN) #1 was interviewed on 11/17/24 at 12:56 p.m. LPN #1 said insulin pens did not need to be primed after applying a new needle. The director of nursing (DON) was interviewed on 12/18/24 at 3:09 p.m. The DON said insulin pens should be cleaned prior to applying the needle and the pen should be primed prior to dialing up the dose. The DON said priming was important to ensure the correct dose was administered, not priming could lead to too much or too little insulin being administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 was interviewed again on 12/19/24 at 9:40 a.m. RN #1 said he administered the Voltaren gel as ordered for Resident #10. He said after reviewing the Voltaren gel order he was able to identify the order was missing a dose. He said he was not aware he needed to use the dosing card inside the Voltaren gel box. RN #1 said he would call the physician immediately to get the dose added to the order. The DON was interviewed again on 12/19/24 at 10:20 a.m. The DON said an order should include the right person, medication, dose, frequency and route. The DON said if the order was missing one of the five rights it was to be corrected immediately to prevent medication error. The DON said her charting system did not allow for the dose to be put in and she would have to figure out how it can be added. The DON said Voltaren gel had a dosing card that should be used to ensure the correct dose is being administered.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review and interviews the facility failed to ensure residents were kept free of significant medication errors for one resident (#3) out of 29 sample residents. Specifically the facility failed to ensure insulin pens were primed prior to medication administration for Residents #3. Cross-reference F759 failure to ensure the medication error rate was less than five percent (%). Findings include: I. Professional reference According to the Instructions for use Humalin R KwikPen, retrieved 12/26/24 from: https://pi.lilly.com/ca/humulin-n-r-ca-ifu-kp.pdf It revealed in pertinent Priming your pen. Prime before injections. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensure the pen is working correctly. If you do not prime the pen before injections, you may get too much or too little insulin. II. Facility policy and procedure The Administering medications policy and procedure, revised April 2019, was received from the nursing home administrator (NHA) on 12/19/24 at 1:29 p.m. It revealed in pertinent part, Medications were administered in a safe and timely manner, and as prescribed. The individual administering medications checks the label three times to verify the right resident, right medication, right dose, right time, and right method (route) of administration before giving the medications. III. Resident #3 A. Resident status Resident #3, age greater than 65, admitted on [DATE]. According to the December 2024 computerized physician orders (CPO) diagnoses included type one diabetes (abnormal glucose control), obesity and paranoid schizophrenia (abnormal thinking process). The 11/22/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. He required set up assistance with personal hygiene. He was independent for eating, dressing, toileting and transfers. The MDS assessment revealed the resident received insulin injections for the past seven days. B. Physician's orders (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2024 CPO documented a physician's order for Resident #3. The order read: Humalin R U-500 kwikPen, Inject 125 units subcutaneously before meals for diabetes. C. Observations On 12/17/24 at 11:40 a.m. registered nurse (RN) #1 was administering medications for Resident #3. The medication ordered was Humalin R U-500 Kwik pen 500 units/milliliter (ml) inject 125 units subcutaneously before meals for diabetes. RN #1 collected the Humalin R pen from the medication cart, applied a new needle to the tip and dialed the insulin pen to 125 units. RN #1 then identified Resident #3, applied gloves, cleansed the site with an alcohol swab and administered the injection via pen into the resident's right lower abdomen. -RN #1 failed to prime the insulin pen for the correct dose of medications (see professional reference above). III. Staff interviews RN #1 was interviewed on 12/17/24 at 12:41 p.m. RN #1 said insulin vials needed to be cleansed with an alcohol swab prior to inserting a needle to draw up the insulin. RN #1 said he was not aware he needed to cleanse the top of the insulin pen prior to applying the needle. RN #1 said he did not know he needed to prime an insulin pen before dialing to the ordered dose. RN #1 said priming would waste the insulin. RN #1 said he would need to find out what the facility protocol on insulin pens was. Licensed practical nurse (LPN) #1 was interviewed on 11/17/24 at 12:56 p.m. LPN #1 said insulin pens did not need to be primed after applying a new needle. The director of nursing (DON) was interviewed on 12/18/24 at 3:09 p.m. The DON said insulin pens should be cleaned prior to applying the needle and the pen should be primed prior to dialing up the dose. The DON said priming was important to ensure the correct dose was administered, not priming could lead to too much or too little insulin being administered.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47064 Based on observations, record review and interviews, the facility failed to ensure food items were stored, prepared, distributed and served under sanitary conditions in the main kitchen. Specifically, the facility failed to have a system in place to monitor the internal water temperature and concentration (parts per million-ppm) of hypochlorite of the dish machine in the main kitchen to ensure tableware, drinkware and cookware were effectively sanitized. Findings include: I. Professional reference The Colorado Retail Food Establishment Rules and Regulations, revised March 2024, retrieved on 12/26/24, read in pertinent part: A test kit or other device that accurately measures the concentration in MG/L (milligrams per liter) of sanitizing solutions shall be provided. (page 125) A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times shall meet the criteria specified in accordance with the EPA- registered label use instructions . A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution as listed in the following chart: The concentration range minimum temperature chart indicated if the MG/L was 25 to 49 and the PH (potential of hydrogen) was 10 or less or the PH was eight or less the temperature of the water needed to be 120F. If the MG/L was 50 to 99 and the PH was 10 or less or eight or less the water needed to be 100F. If the MG/L was 100 and the PH was 10 or less or eight or less the water needed to be 55F. The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 F. (page 129 to 130) II. Facility policy and procedure The Dishwashing Machine Use policy and procedure, revised March 2010, was received from the nursing home administrator (NHA) on 12/19/24 at 1:29 p.m. It revealed in pertinent part, Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation . Dishwashing machine chemical sanitizer concentrations and contact times will be as follows: (continued on next page)

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Lakewood Villa	1625 Simms St Lakewood, CO 80215

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	If the solution is chlorine the minimum concentration is 50 to 100 ppm with a contact time of 10 seconds. If the solution is iodine the minimum concentration is 12.5 ppm with a contact time of 30 seconds. If the solution is quaternary ammonium the minimum concentration is 150 to 200 ppm and the contact time is per the manufacturer's instructions. A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution (measured as parts-per-million [PPM] or mL/L) after filling the dishwashing machine and once a week thereafter. Concentrations will be recorded in a facility approved log. Corrective action will be taken immediately if sanitizer concentrations are too low. The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log. The operator will monitor the gauge frequently during the dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. The supervisor will check the calibration of the gauge weekly by running a secondary thermometer through the machine to compare temperatures; or using commercial temperature test strips following manufacturer's instructions. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machines immediately until temperatures or ppm are adjusted. III. Observations and staff interviews On 12/16/24 at 9:08 a.m. the kitchen dish machine was in use after the breakfast meal. The dietary manager (DM) said the dish machine used chemicals for sanitization. There were no test strips available to test the chemical solution. The DM said they ran out of test strips two or three days prior. The DM said the staff were using the temperature on the machine for monitoring the effectiveness of disinfecting until the test strips were delivered. The dish machine was 130F. On 12/18/24 at 1:25 p.m. the dishwasher was in use. The DM said he still had not received test strips to check the dishwashing machines chemical use. The dish washer temperature was 130F. Dietary aide (DA) #1 was interviewed on 12/18/24 at 1:30 p.m. She said she checked the temperature on the dish machine once per meal. DA #1 said she recorded the temperature on the log sheet. The November 2024 (11/1/24 to 11/30/24) and December 2024 (12/1/24 to 12/19/24) machine log sheets were reviewed with DA #1 and she confirmed there were days that were missing temperature monitoring of the dish machine. DA #1 said she did not know what was an acceptable temperature. DA #1 said she had never tested the dishwasher chemicals. IV. Record review (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The dishwasher temperature log from 11/28/24 to 12/19/24 was reviewed on 12/19/24 at 1:58 p.m. it documented the following: -On 11/28/24 there was not a temperature logged for the dinner service; -From 11/30/24 to 12/5/24 there were no temperatures logged; -On 12/7/27 there were no temperatures logged for the lunch or dinner service; -On 12/8/24 the temperature was 115F for breakfast service with no corrective action documented; -From 12/9/24 to 12/12/24 there were no temperatures logged; -On 12/13/24 there were no temperatures logged for the lunch or dinner service; -On 12/14/24 the temperature was 110F for breakfast and 100F for lunch. There was no temperature logged for dinner services. -On 12/15/24 the temperature was 100F for breakfast service. -On 12/16/24 the temperature was 110F for breakfast and there was no temperature logged for dinner service. -On 12/17/24 there was no temperature logged for dinner service. -The dishwasher machine log had no place to document the ppm was being monitored. The dishwasher log failed to consistently document the temperature of the dishwasher, along with no testing of the ppm for chemical sanitization. The log documented several days with temperatures out of range (see professional reference above). V. Additional staff interviews DA #2 was interviewed on 12/18/24 at 1:51 p.m. He said from time to time he would assist with washing dishes. DA #2 said the temperature on the dishwashing machine should be between 35 and 45 degrees fahrenheit. DA #2 said they were to use the dip sticks in the dishwasher to ensure the proper amount of chemical was being used for disinfecting purposes. DA #2 said the dip stick should be a green to dark green color to be in the correct range. DA #2 said he did not know the ppm levels the dishwasher should read during testing. The infection preventionist (IP) was interviewed on 12/19/24 at 10:27 a.m. The IP said the dishwasher chemicals were dispensed from a machine. The IP said she did not know what the chemical concentration needed to be to ensure proper sanitization. The IP said the dish machine was a low temperature dishwasher that used chemicals to sanitize the dishes. The IP said she needed to check with the DM for the correct intervals the dishwasher should be checked, but she believed it was every four hours. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The IP said it was important for the dish machine to be functioning appropriately to ensure proper sanitization of dishes to prevent spread of infection. The DM was interviewed on 12/19/24 at 1:16 p.m. He said he had been educated to ensure the dishwasher temperature was at least 120F and the ppm should be between 50 and 100 for chlorine. The DM said he would call the chemical servicing company if they discovered the chemical dispensing was inaccurate based on testing strips. The DM said if the dishwasher was not working the dietary staff would washing dishes manually in the sink and the ppm would be checked of the sanitizer in the sink to ensure it was effectively sanitizing. The DM said he had testing strips the whole time during the survey. The DM said he did not know he could use the same testing strips he used on his sanitization buckets. The DM said the staff were responsible for documenting the ppm and the temperatures for all areas that chemicals were used in the kitchen. The DM said the manager on duty was responsible for checking the logs on the weekends or when he was not in the facility to ensure they were filled out daily. The DM said he was not sure why the logs were not being completed or how the log sheet did not have a section for ppm to be recorded. The DM said he would be completing education to the staff. He said he would change the log sheets immediately to ensure the temperatures and ppm could be recorded appropriately. The DM said he tested the ppm on the dishmachine once he learned he could use the same strips and it was above 50 ppm.

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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	HSK #1 used hand sanitizer, donned gloves and entered room [ROOM NUMBER]. She removed the toilet brush from the cart and proceeded to the bathroom. The toilet seat had feces on it and there was feces in the toilet bowl. She did not flush the toilet. She used the toilet brush to clean the inside of the toilet bowl and then used the brush to clean the feces off the seat. She placed the toilet brush back onto the cart and removed her gloves. She used hand sanitizer and donned clean gloves. She removed the broom from the cart and began sweeping the room. She moved the night stand and swept behind it. A comb and tube of toothpaste was in the debris. She picked up the items and shook them off. She placed both items back onto the night stand. There was still debris in the comb. She swept the rest of the debris to the doorway and picked it up with the dust pan. She removed the disinfectant and a green rag from the cart. She wet the rag at the sink and proceeded to the bathroom. She sprayed the toilet with disinfectant and used the rag to wipe it. She first wiped the tank, the seat, under the seat, the rim, the side of the toilet and the sides. She sprayed the window sill and used a clean rag to wipe it. She returned the spray bottle and the soiled rags to 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 and emptied the trash. She removed the soiled mop pad and replaced it with a clean mop pad from the water bucket. She did not spray the second mop pad with a cleaner. She then mopped the bathroom floor. She placed the mop pad and handle back onto the cart. She removed a small container of a soap solution and a scrubbing pad. She washed the inside of the sink. She again splashed water onto the sink top and mirror and wiped them dry with a paper towel. She placed a wet floor sign at the door entrance and exited the room. -HSK #1 failed to use the toilet brush only on the inside of the toilet and use a disinfectant on the toilet. She failed to discard the comb and tooth paste into the trash and placed them back on the night stand to be used. She failed to use a disinfectant when mopping the bathroom floor and failed to use a disinfectant while cleaning the sink. She failed to clean horizontal surfaces and high touch surfaces. D. Staff interviews HSK #1 was interviewed on 12/18/24 at 10:37 a.m. HSK #1 said she used the container of dish soap and water, with the scrub pad, to clean the sink in all the resident's rooms. She said she changed the scrub pad once a week and used the dish soap because she felt it was the best product to disinfect with. She said the toilet brush should only be used for the inside of the toilet bowl, but since there was dried feces on the seat she had to use the toilet brush to clean the seat. She said the toilet should have been cleaned from top to bottom. She said she used the toilet brush to clean the seat, because she did not have another rag. She said high touch areas, such as door knobs, grab bars, sink handles and call lights should be cleaned daily. She said there was only water in the mop bucket, but she sprayed the mop with a cleaner to rid the room of odors. (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)

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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)

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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 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.