STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065410	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbine Commons Health & Rehab LLC	1475 Main St Windsor, CO 80550

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52309 Based on record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain grooming and personal hygiene for one (#8) of four residents reviewed out of 17 sample residents. Specifically, the facility failed to provide Resident #8 with timely bathroom assistance. Findings include: I. Facility policy and procedure The Resident Rights policy, revised on 2/26/25, was provided by the nursing home administrator (NHA) on 4/18/25 at 4:14 p.m. It read in pertinent part, The resident has the right to be treated courteously, fairly and with the fullest measure of dignity, and to be cared for in a manner and environment that promotes maintenance or enhancement of his or her quality of life. II. Resident #8 A. Resident status Resident #8, age greater than 65, was admitted [DATE]. According to the April 2025 computerized physician order (CPO), diagnoses included atrial fibrillation (heart condition), chronic diastolic (congestive) heart failure, anxiety disorder and unspecified pain. The 3/20/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. She required substantial to maximum assistance with toileting hygiene and toilet transfers. Resident #8 was interviewed on 4/16/25 at 1:00 p.m. Resident #8 said she had to wait 40 minutes sitting on the toilet until she received assistance (the morning of 4/16/25). She had to scream and bang on the wall. B. Resident interview (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8 was interviewed again 4/16/25 at 2:45 p.m She said she was assisted to the bathroom and when finished she pushed the call box (a device used to signal for help) in her bathroom. She said she waited a long time and pushed the call box again and then her personal pendant for help. She said she sat on the toilet for 40 minutes and then started to scream and bang on the wall for help. Resident #8 said she did not want that to happen again. C. Record review The activities of daily living (ADL) functional care plan initiated 3/13/24 and revised on 4/1/25, indicated Resident #8 had experienced a decline in function with increased weakness. Pertinent interventions included provide assistance for ADLs and mobility as needed, provide moderate assistance with toileting. The cognitive loss care plan initiated 3/14/24 and revised on 3/20/25, indicated that Resident #8 has short term and long term memory loss. Pertinent interventions included anticipate and assist with needs and ADL's as appropriate and monitor every one to two hours and as needed (PRN) for safety or needs The 4/16/25 computerized response time log for Resident #8 was provided by the director of nursing (DON) on 4/16/25 at 1:58 p.m. It indicated the following: Resident #8 activated her personal pendant at 6:35 a.m. and it was deactivated nine minutes later. Resident #8 activated the bathroom call box at 6:57 a.m., which was on the wall located next to the toilet. The call box was deactivated at 7:09 a.m., 12 minutes later. Resident #8's personal pendant was activated at 7:09 a.m. Resident #8's personal pendant was deactivated at 7:24 a.m., 15 minutes after the personal pendant was activated. -Resident #8 initially activated her bathroom call box at 6:57 a.m., the call box was deactivated at 7:09 a.m., then her personal pendant was activated at 7:09 a.m. Resident #8 did not receive assistance for 27 minutes after she initially activated her call box, leaving her on the toilet for approximately 40 minutes. D. Staff interviews The DON and the social services director (SSD) were interviewed together on 4/16/25 at 1:58 p.m. The DON said the residents had two ways to notify staff that they needed assistance, the call box and their personal pendants. The DON said the call box could be deactivated in the room by a button and the personal pendant had to be deactivated by a staff member. The SSD said Resident #8's statement on the wait time was valid. The DON said Resident #8 may have deactivated the bathroom call box by pushing the deactivation button, which was located under the activation button on the call box. She said this would have sent an automated message that the light has been cleared. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nursing aide (CNA) #1 was interviewed on 4/16/25 at 2:25. CNA #1 said that CNAs were assigned to a hall and not specific rooms. She said the CNAs were responsible for answering all call notifications in their assigned hall. She said after the call box or personal pendant was deactivated a message was sent over the walkie talkie as cleared. CNA #1 said that she did not check on residents after the call notification had been cleared. CNA #2 was interviewed on 4/17/25 at 10:45 a.m. CNA #2 said she answered the call notification that morning and assisted Resident #8 to the toilet on 4/16/25 (at 6:44 a.m.) CNA #2 said she had told Resident #8 to call when she was finished. CNA #2 said she heard Resident #8's call notification, then heard the clear signal several minutes later. She said she heard Resident #8's call notification again and was going to assist her when she finished with another resident. She said she then heard Resident #8 screaming and banging on the wall. She said she entered the bathroom to assist the resident off the toilet.

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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. 48412 Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen and two out of two kitchenettes. Specifically, the facility failed to ensure: -Refrigerators were maintained at the correct temperature; -Food was properly stored after being opened; -Staff wore beard nets in the kitchen; -Staff did not have fake nails; and, -Staff did not wear a watch on their wrist while serving food. Findings include: I. Failure to ensure refrigerator temperatures were maintained appropriately A. Professional reference The Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/18/25. It revealed in pertinent part, Time or temperature control for safety food shall be maintained at 41 degrees Fahrenheit (F) or less. (Chapter 3) B. Facility policy and procedure The Kitchen Sanitation policy, revised 2023, was provided by the nursing home administrator (NHA) on 4/21/25 at 11:03 a.m. It read in pertinent part, Refrigerated food should be stored at or below 41 degrees Fahrenheit (F). C. Observations On 4/15/25 at 9:20 a.m. a tour of the kitchenette in the Lakes building revealed the bottom left refrigerator had an internal thermometer that read 46 degrees F. The refrigerator contained sodas, milk and yogurt. C. Staff interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The dietary manager (DM), the registered dietitian (RD) and assistant dietary manager (ADM) were interviewed together on 4/16/25 at 2:15 p.m. The DM said he was unaware the refrigerator temperature was above 41 degrees F. He said he was going to have maintenance look at the refrigerator and provide education to the staff about notifying him if a refrigerator was at the wrong temperature. II. Failure to ensure food was properly stored A. Professional reference The Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/18/25. It revealed in pertinent part, Food shall be discarded if it is in a container or package that does not bear a date. (Chapter 3) B. Facility policy and procedure The Kitchen Sanitation policy, revised 2023, was provided by the NHA on 4/21/25 at 11:03 a.m. It read in pertinent part, All time and temperature control for safety (including leftovers) should be labeled, covered and dated when stored. When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. C. Observations On 4/15/25 at 9:20 a.m. a tour of the kitchenette in the Lakes building revealed a bag of French fries in the freezer that were not sealed shut or labeled with an open date. There was a bag of cheesecake mix in the dry storage area that was not sealed or labeled with an open date. On 4/15/25 at 11:15 a.m. a tour of the kitchenette in the Mountains buildings revealed a box of barley that was not sealed or labeled with an open date. D. Staff interviews The DM, the RD and the ADM were interviewed together on 4/16/25 at 2:15 p.m. The DM said once food was opened from its original packaging, it needed to be sealed and labeled with an open date and a use-by date. III. Failure to ensure beard nets were worn A. Professional reference (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/18/25. It revealed in pertinent part, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens and unwrapped sing-service and single-use articles. (Chapter 2) B. Facility policy and procedure The Kitchen Sanitation policy, revised 2023, was provided by the NHA on 4/21/25 at 11:03 a.m. It read in pertinent part: Beard nets are required when facial hair is visible. C. Observations On 4/15/25 at 11:15 a.m. a tour of the kitchenette in the Mountains buildings revealed cook (CK) #2 wore a surgical mask due to COVID-19 in the building. CK #2 was not wearing a beard net, he wore a surgical mask and his beard was sticking out from under the mask. D. Staff interviews The DM, the RD and the ADM were interviewed together on 4/16/25 at 2:15 p.m. The DM said a surgical mask did not count as a beard net and that beard nets needed to be worn when the staff had a five o ' clock shadow or longer beard hair. He said CK #2 should have worn a beard net with his surgical mask. IV. Failure to ensure staff did not wear fake nails when handling food A. Professional reference The Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/18/25. It revealed in pertinent part, Unless wearing intact gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with exposed food. (Chapter 2) B. Facility policy and procedure The Kitchen Sanitation policy, revised 2023, was provided by the NHA on 4/21/25 at 11:03 a.m. It read in pertinent part, Keep fingernails clean and neat. Acrylic or painted nails must be covered when handling or serving food. C. Observations (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a continuous observation on 4/16/25, beginning at 11:00 a.m. and ending at 12:30 p.m., CK #1 was wearing fake nails that were painted a beige color and approximately half an inch long while she served lunch without gloves on. D. Staff interviews The DM, the RD and the ADM were interviewed together on 4/16/25 at 2:15 p.m. The DM and the RD said the staff were not allowed to wear fake nails. The DM and the RD said CK #1 needed to have gloves on while serving lunch because she had artificial fingernails. V. Failure to ensure staff did not wear watches while preparing food A. Professional reference The Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/18/25. It revealed in pertinent part, Except for a plain ring such as a wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. (Chapter 2) B. Observations During a continuous observation on 4/16/25, beginning at 11:20 a.m. and ending at 12:30 p.m. CK #1 was wearing a smart watch while she served lunch. C. Staff interviews The DM, the RD and the ADM were interviewed together on 4/16/25 at 2:15 p.m. The RD said the facility ' s policy allowed watches to be worn, but that she was going to get the policy updated to match the regulations.