STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065413	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Cordera	9208 Grand Cordera Pkwy Colorado Springs, CO 80924

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31229 Based on observations, record review and interviews, the facility failed to provide adequate supervision and assistance devices to prevent accidents for two (#30 and #5) of six residents reviewed for falls out of 28 sample residents. Resident #30, who was severely cognitively impaired and had a history of falls, was admitted to the facility on [DATE] after a fall at home which resulted in a left hip fracture requiring surgical repair. Upon the resident's admission, the facility initiated a fall care plan with generalized interventions that were implemented for all residents, including an intervention to ensure the resident's call light was within reach and a Call, don't fall sign was to be posted in the resident's room. -However, the facility failed to appropriately assess Resident #30's ability to use her call light and understand what the Call, don't fall sign was for due to her severe cognitive impairments. The facility did not implement person-centered fall interventions that were specific to Resident #30 and staff were not educated regarding the resident's increased need for supervision to prevent falls. On 7/26/24, Resident #30 sustained a fall from bed without injury. The immediate interventions were to remind the resident to use her call light, despite the fact the resident had severe cognitive impairments and frequent checks by staff for safety. On 8/1/24, Resident #30 sustained a second fall, this time in her bathroom. The resident complained of increased left hip pain and was transferred to the hospital where it was discovered the resident had refractured her left hip, requiring a second surgical repair. Due to the facility's failures to implement timely person-centered fall interventions and ensure staff were aware of the resident's increased need for supervision, Resident #30 sustained two falls within 13 days of being admitted to the facility, with the second fall resulting in a major injury. Additionally, for Resident #5, the facility failed to implement timely person-centered fall interventions and ensure staff were aware of the resident's increased risk for falls due to Parkinson's disease. Between 7/9/24, the date the resident admitted to the facility, and 8/15/24, Resident #5 sustained seven falls. Two of the falls occurred on 8/15/24 within one hour and 15 minutes of each other. Findings include: (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	I. Facility policy and procedure The Fall Prevention policy, revised July 2023, was provided by the nursing home administrator (NHA) on 8/28/24 at 1:05 p.m. It read in pertinent part, Falls in the skilled nursing setting represent one of the most potentially devastating occurrences that can negatively impact a resident's recovery. In facilities, falls directly cause tens of thousands of bone fractures, intracranial hemorrhages, re-hospitalization s, and deaths every year in the United States. It is because of these unfortunate events that the facility is implementing its comprehensive program to prevent falls and injury. Procedure: Any resident deemed to be high risk by nursing and/or therapy staff will have the following interventions at least considered: -Thorough physical and occupational therapy evaluation; -Low bed (or lower standard bed to its lowest position); -Routine toileting schedule throughout shift; -Line of sight as needed; -Nursing staff as needed; -Consult pharmacist to review medications as needed; -Encourage resident to participate in monitored activities; and, -Move the resident to a room closer to the nurse's station. Dementia or altered mental status, not oriented: -Admit in a room closest to the nurses' station or observation room if available; -Routine toileting schedule throughout the shift; -Residents not to be left alone in the bathroom; and, -Round on residents throughout the shift. Post fall procedure: -Determine what interventions need to be implemented to prevent further falls; and, -Complete orders and/or tasks for fall prevention. II. Resident #30 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A. Resident status Resident #30, age 88, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, other mechanical complication of internal fixation device of left femur, subsequent encounter, mild cognitive impairment, type 2 diabetes mellitus with hyperglycemia, muscle weakness, unspecified dementia and periprosthetic fracture (broken bone that occurs around an orthopedic implant) around internal prosthetic left hip joint. The 7/25/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of two out of 15. She required substantial/maximum assistance with toileting, bathing, and partial/moderate assistance with transfers. B. Resident observation and staff interview Resident #30 was observed on 8/26/24 at 12:40 p.m. in the nurses' station area. She was sitting in a wheelchair with her eyes closed. Registered nurse (RN) #1 said Resident #30 fell a few weeks ago (8/1/24) and refractured her left hip. She said on readmission, the resident was placed in the observation room close to the nurses' station for safety. RN #1 said the resident could not use the call light. She said the staff frequently brought Resident #30 to the nurses' station to keep an eye on her. She said Resident #30 had not made any physical progress since her readmission, had quit eating food and would be discharged to a hospice care facility. C. Record review Resident #30's activities of daily living (ADL) care plan, initiated 7/19/24, revealed the resident had an actual/potential decline in her ability to perform her ADLs due to impaired mobility related to a left hip fracture with surgical repair. Interventions included encouraging the resident to do as much as possible for herself as able, placing the call light within reach and providing assistance as needed with grooming, bathing and personal hygiene and per the resident's preferences. The transfers/toileting care plan, initiated 7/19/24, revealed the resident required assistance with transfer/toileting related to impaired mobility secondary to weakness and debility. Interventions included checking on the resident frequently and assisting with toileting as needed, keeping the call light within reach and reminding the resident to call for assistance. -The care plan did not indicate how often the resident should be checked on. The fall care plan, initiated 7/19/24, revealed the resident was at risk for falls related to impaired mobility secondary to weakness and debility, a fall with a left hip fracture prior to admission, cognitive impairment and the resident's current drug regimen. Interventions included keeping the call light within reach, reinforcing the need to call for assistance and wearing proper non-slip footwear. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-However, Resident #30 had severe cognitive impairments and her ability to remember to use the call light or call for assistance was impaired. The high risk faller care plan, initiated 7/19/24, revealed the resident was at high risk for falls but was aware she might have a fall with major injury. Interventions included placing a Call, don't fall sign in the resident's room to remind the resident to call for assistance and having adequate lighting. -However, Resident #30 had severe cognitive impairments and her ability to remember to use the call light or call for assistance was impaired. The actual fall care plan, initiated 7/26/24, revealed Resident #30 was at risk for further falls related to attempting to self transfer without calling for assistance, functional/clinical decline, impulsivity and poor safety awareness. Interventions included placing a Call, don't fall sign in the resident's room to remind the resident to call for assistance and rounding on the resident throughout the shift. -However, Resident #30 had severe cognitive impairments and her ability to remember to use the call light or call for assistance was impaired. -The care plan did not indicate how often the resident should be rounded on during the shift. -None of the above care plans were updated with additional fall interventions upon Resident #30's readmission to the facility following her fall with major injury, hospitalization and surgical repair of her refractured left hip. 1. Fall #1 A nurse progress note dated 7/26/24 documented the resident was found on the floor by certified nurse aide (CNA) at 6:30 a.m. When the nurse entered the resident's room, the resident was sitting on the floor near the bed. The resident was confused and said she tried to get up from the bed and slid on the floor but did not hit her head. The resident was assessed, able to move both hands and her right leg. She was not able to move her left leg due to her recent left hip repair. No injuries were noted. The resident was educated and reminded to use her call light for all transfers and needs. Frequent checks by staff for safety were implemented and the resident was assisted back to bed by two staff members with the use of a gait belt. The family and the physician were notified and an order for an x-ray was obtained as a precaution. A post fall evaluation dated 7/26/24 documented the probable cause of the fall was the resident did not use her call light and tried to get out of bed by herself. The resident was confused. -However, the intervention after the fall, despite the resident's cognitive impairments and confusion, was to remind the resident to use the call light. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The interdisciplinary team's (IDT) review of the 7/26/24 fall documented the resident had no change in her level of consciousness or orientation status. The provider ordered bilateral hip x-rays after the fall, which her negative for any new fractures. The resident was verbally educated on call light use and verbalized verbalized understanding. Current fall interventions included a Call, don't fall sign. A new intervention for frequent checks was initiated and the resident would continue to work with therapy on balance and strength training. A physician's note dated 7/29/24 documented Resident #30's cognitive impairment was likely consistent with at least mild dementia. The resident did not have agitation but the resident was unable to provide much meaningful information and seemed to be repetitive. A social services note dated 7/30/24 documented Resident #30 was drowsy and unable to stay awake long enough to discuss the Notice of Medicare Non-coverage (NOMNC). The resident was only able to score a two out of 15 on BIMS assessment. -However, despite the resident's cognitive impairments and confusion, the facility continued to utilize reminding the resident to use the call light as a fall intervention. 2. Fall #2 A nurse progress note dated 8/1/24 documented a RN was called to the resident's room for a reported fall. The resident was found on the floor in the bathroom, diagonally between the shower and the toilet. The resident was complaining to her post-surgical left hip. The RN assessed the resident and the surgical site was reasonably intact, however, there was suspicion the resident re-injured or refractured her left hip. The physician was notified and a physician's order was obtained to send the resident to the hospital for further assessment and treatment. The resident's family was notified. A post fall evaluation dated 8/1/24 documented the probable cause of fall was the resident's non-compliance with call light use, self-ambulating without assistance from staff and poor safety awareness. The IDT's review of the 8/1/24 fall documented the resident had no change in her level of consciousness or orientation status. Current fall interventions included a Call, don't fall sign. The resident was sent to the hospital due to concerns for re-injury to her left hip. Per the 8/1/24 hospital left hip x-ray (see hospital record below), worsening of the left hip fracture was noted. The resident was admitted to the hospital. The resident would be admitted into an observation room upon her readmission to the facility. A hospital progress note dated 8/1/24 documented the resident was a very pleasant female who sustained a ground level fall and was brought to the emergency department with a periprosthetic femur fracture. She had undergone cephalomedullary nailing of a left intertrochanteric femur fracture about two and half weeks prior. On 8/1/24 she was in a rehabilitation facility and sustained an unwitnessed fall. Upon presentation to the emergency department, she was noted to have a periprosthetic femur fracture around the short cephalomedullary nail that had been placed. The injury was discussed with the resident's legal representative regarding the diagnosis and treatment alternatives, including the risks of surgery. The resident's representative expressed understanding of the risks and desired to proceed with surgery. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #30 readmitted to the facility on [DATE] and was admitted into an observation room close to the nurses station (see interviews below). A social services note dated 8/14/24 documented the social worker spoke with the resident and family during a care conference. The discussion included information about hospice care and needs for next level care at home. The family was provided pamphlets about hospice services, Medicaid assistance and caregiving services. A nurse progress note dated 8/26/24 (during the survey) documented Resident #30 was discharged at 2:25 p. m. to another facility with hospice care services. D. Staff interview The director of rehabilitation (DOR) was interviewed on 8/29/24 at 10:45 a.m. The DOR said Resident #30 was initially admitted on the third floor, however, after two falls and the hospitalization , she was readmitted to the observation room close to the nurses station on the second floor on 8/3/24. He said he was not aware Resident #30 could not use a call light. III. Resident #5 A. Resident status Resident #5, age 69, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included acute cystitis (inflammation of the bladder) with hematuria (blood in the urine), Parkinson's disease, insomnia, benign prostatic hyperplasia (noncancerous enlargement of the prostate gland) with lower urinary tract symptoms, type 2 diabetes mellitus, overactive bladder, unspecified mood disorder, history of transient ischemic attack (TIA) and cerebral infarction (stoke) and the presence of a neurostimulator (a device that uses electrical stimulation to treat neurological and psychiatric disorders). The 7/13/24 MDS assessment revealed the resident's cognition was intact with a BIMS score 14 out of 15. The resident did not have rejection of care and no behaviors were noted. The resident's range of motion of upper and lower extremity was impaired on both sides. He was dependent on staff with toileting and required substantial/maximal assistance with all transfers (bed/wheelchair/toilet). B. Resident and family interview Resident #5 and his wife were interviewed together on 8/26/24 at 2:30 p.m. Resident #5 said he was not aware how to use the call light for the first few days in the facility and he did not realize he was not strong enough to transfer himself from his bed to his wheelchair. Resident #5's family member said, with his Parkinson's diagnosis, Resident #5 was falling frequently at home when she was at work and the facility was aware of the resident's poor safety awareness upon his admission to the facility. She said Resident #5 had previously sustained traumatic brain injuries and he did not realize he needed assistance with transfers. C. Record review (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #5's ADL care plan, initiated 7/9/24, revealed the resident had actual/potential decline in his ability to perform his ADLs due to impaired mobility related to Parkinson's disease. Interventions included encouraging the resident to do as much as possible for himself as able, placing the call light within reach and providing assistance as needed with grooming, bathing and personal hygiene and per the resident's preferences. The bowel incontinence care plan, initiated 7/9/24, revealed the resident was incontinent of bowel due to impaired mobility. Interventions included checking on the resident frequently and assisting with toileting as needed, keeping the call light within reach and reminding the resident to call for assistance. -The care plan did not indicate how often the resident should be checked on. The transfers/toileting care plan, initiated 7/9/24, revealed the resident required assistance with transfer/toileting related to weakness and debility. Interventions included checking on the resident frequently and assisting with toileting as needed, keeping the call light within reach and reminding the resident to call for assistance. -The care plan did not indicate how often the resident should be checked on. The fall care plan, initiated 7/9/24, revealed the resident was at risk for falls related to impaired mobility secondary to weakness and debility, Parkinson's disease, history of falls, neuropathy (a nerve disease or damage that can cause pain, numbness, or tingling in different parts of the body) and the resident's current drug regimen. Interventions included keeping the call light within reach, keeping commonly used items within reach, occupational therapy (OT) and physical therapy (PT) to evaluate and treat as needed. The actual fall care plan, initiated 7/25/24, revealed the resident had a fall at the facility and was at risk for further falls related to attempting to transfer without assistance, confusion, functional/clinical decline, impulsivity and poor safety awareness. Interventions initiated on 7/25/24 included placing a Call, don't fall sign in the resident's room to remind the resident to call for assistance, utilizing the 4 P's, including asking does the resident need to use the bathroom, does the resident need to be repositioned, are all commonly used belongings within reach of the resident, and is the resident having pain and notifying the nurse immediately if the answer to pain was yes. Interventions initiated 8/16/24 (after seven falls - see falls below) included the use of a fall mat, keeping the bed in a low position while the resident was in bed, keeping the call light within reach at all times, using a motion sensor, moving the resident closer to the nurses station, rounding on the resident throughout the shift and providing a soft touch call light. -The care plan did not indicate how often the resident should be rounded on throughout the shift. -Despite Resident #5's intact cognition BIMS score of 14 out of 15, the facility failed to appropriately assess Resident #5's ability to use his call light for assistance based on his history of traumatic brain injuries (see family interview above). The 7/9/24 Comprehensive Nursing Assessment revealed Resident #5's fall risk score was 40, which indicated he was a moderate risk for falls. (continued on next page)

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	065413	A. Building B. Wing	08/29/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. Fall #1 A nurse progress note dated 7/24/24 at 3:50 a.m. documented a RN was called to Resident #5's room for a reported fall by the CNA. The resident was found lying on the floor parallel to his bed on his right side. The resident was alert with clear and discernible speech and no changes in mentation were noted. No injuries noted. The resident had little to no stated or observable pain. When asked what he was doing the resident said he fell out of bed but he did not know why he was trying to get out of bed. Staff was able to transfer the resident, once assessed, back to his bed. He was reassessed and no injuries were noted. Vital signs and neurological checks were started per protocol. The physician and family were notified. A post fall evaluation dated 7/24/24 documented the probable cause of the fall was the resident had very poor safety awareness with short term memory loss. -However, despite the resident's poor safety awareness and short term memory loss, the facility continued to utilize reminding the resident to use the call light and call for assistance as a fall intervention. The IDT's review of the 7/24/24 fall documented the resident had no change in his level of consciousness or orientation status. The resident obtained no injuries from the fall. Current fall interventions included a Call don't fall sign. New interventions initiated included the Fall Program and frequent rounding. The resident was verbally educated on the importance of call light use and the resident verbalized understanding. The resident would continue to work with therapy on balance and strength training. -Despite the resident's poor safety awareness and short term memory loss, the facility continued to utilize reminding the resident to use the call light and call for assistance as a fall intervention. 2. Fall #2 A nurse progress note dated 7/28/24 documented Resident #5 had an unwitnessed fall at 12:00 a.m. after staff did rounds on him at 11:45 p.m. He was found by staff on the left side of his bed sitting on his legs and left foot with his knees bent. The resident had a superficial scratch on his left knee and his catheter had been pulled out of the securing device attached on his left leg. The resident reported he was trying to turn off his television (TV). The RN evaluated the resident and CNAs and the RN transferred the resident back to bed. Neurological checks were initiated. -A Post Fall Evaluation dated 7/28/24 failed to document the probable cause of the fall. The IDT's review of the 7/28/24 fall documented the resident obtained no injuries from the fall and had no change in his level of consciousness or orientation status. The resident was verbally re-educated on safety and call light use. Current interventions included a Call don't fall sign, frequent rounding and the 4 P's. The resident remained on the fall program. The facility planned to move the resident to an observation room once one was available. The resident would continue to work with therapy on strength training and balance. 3. Fall #3 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse progress note dated 7/30/24 at 11:49 p.m. documented a RN was called to the resident's room with a suspected fall. The resident was found on the floor on his left side facing the bed, holding the bed tightly by the footboard handles, with a big grin on his face and saying he needed help. When asked, the resident stated he was needing help,and that's why he thought he might be on the floor. The resident was assessed, no injuries were noted and the resident was able to answer all inquiries per his baseline mentation. The resident returned to his bed and was reassessed with no injuries found, however, he needed to be changed which was what possibly perpetuated the fall. The physician and family were notified. Vital signs and neurological checks were restarted per protocol. -A post fall evaluation dated 7/30/24 failed to document the probable cause of the fall. The IDT's review of the 7/30/24 fall documented the resident obtained no injuries from the fall and had no change in his level of consciousness or orientation status. The resident was verbally re-educated on safety and call light use. Current interventions included a Call don't fall sign, frequent rounding and the 4 P's. The resident remained on the fall program. The facility planned to move the resident to an observation room once one was available. A medication review was completed on the resident by the physician and new orders were obtained to discontinue the resident's scheduled Ambien. The resident would continue to work with therapy on strength training and balance. 4. Fall #4 A nurse progress note dated 8/6/24 at 6:24 a.m. documented the RN was called to the resident's room and no injuries were noted. The resident was assessed and returned to bed. Vital signs and neurological checks were started per protocol. The physician and family were notified. -A post fall evaluation dated 8/6/24 failed to document the probable cause of the fall. The IDT's review of the 8/6/24 fall documented the resident obtained no injuries from the fall and had no change in his level of consciousness or orientation status. The resident was verbally re-educated on safety and call light use. Current interventions included a Call don't fall sign, frequent rounding and the 4 P's. The resident remained on the fall program. A new intervention was implemented for a motion sensor at night. The resident would continue to work with therapy on strength training and balance. -However, staff was not aware the motion sensor needed to be turned on when the resident went to bed at night (see interviews below). 5. Fall #5 A nurse progress noted dated 8/13/24 at 2:15 p.m. documented the nurse responded to Resident #5's fall and immediately placed a pillow underneath the resident's head for comfort. Neurological checks were within normal limits and the resident denied a headache, nausea or vomiting or vision changes. There was no immediate bruising or redness noted to any areas assessed. The resident's range of motion was intact as prior to the fall and there was no lengthening or shortening of his upper or lower extremities noted. The resident's speech was soft, but clear and understood. The resident was transferred to his wheelchair with the assistance of two staff members and a gait belt and tolerated it well. The resident was taken to the nurses' station/common area for one-to-one supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The facility failed to document a Post Fall Evaluation or IDT review for the fall. -The progress note failed to document any new fall interventions put into place following the fall. 6. Fall #6 A nurse progress note dated 8/15/24 at 9:20 p.m. documented a CNA notified the nurse about the resident lying on the floor lying on his back. He was alert and oriented to person and place. The resident stated he crawled from his bed, kneeled down to the floor and continued to crawl out to the door. He said he did not fall but wanted to get out of his room. The resident said he did not hit his head. His range of motion was within normal limits and he denied pain. The resident was able to follow all commands. He was assisted to sit in his chair and able to bear weight on both of his legs/feet. Neurological checks and monitoring were initiated. -The facility failed to document a post fall evaluation or IDT review for the fall. -The progress note failed to document any new fall interventions put into place following the fall. 7. Fall #7 A nurse progress note dated 8/15/24 at 10:35 p.m. documented the resident's spouse was visiting and informed the nurse the resident was on the floor. The nurse found the resident crawling on his hands and knees in the doorway. There were no injuries noted. The fall was unwitnessed. The resident stated that he rolled onto his side and crawled onto the floor. The resident became a little upset when asked if he hit his head. He stated he did not hit his head. A RN assessed the resident and the resident was placed in his wheelchair after the assessment. The resident's spouse and the physician were notified. Neurological checks were initiated and the resident would continue to be monitored. -The progress note failed to document any new fall interventions put into place following the fall. -The facility failed to document a post fall evaluation for the fall. The IDT's review of the 8/15/24 fall documented the resident obtained no injuries from the fall and had no change in his level of consciousness or orientation status. The resident was verbally re-educated on safety and call light use. Current interventions included a Call don't fall sign, frequent rounding the 4 P's, a motion sensor and the resident was in an observation room. The resident remained on the fall program and the resident's wife was often at the resident's bedside. Activities would continue to offer more one-to-one activities with the resident. A request was made for a soft touch call light and a fall mat was added for resident safety due to the resident's frequent falls. The resident would continue to work with therapy on strength training and balance. D. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 8/27/24 at 8:20 p.m. LPN #2 said he was not aware of any specific interventions for Resident #5 for falls prevention. He said the staff usually did rounds to check on all residents. He did not specify how frequent the rounds were. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065413	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Cordera	9208 Grand Cordera Pkwy Colorado Springs, CO 80924

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #3 was interviewed on 8/27/24 at 8:24 p.m. CNA #3 said he was not aware Resident #5 was at risk for falls and had already had several falls while in the facility. He said he usually did rounds when he was not busy with residents' care, however, he said there was no specific time frame to do frequent rounds. He said he was not aware there was a motion sensor in the resident's room that needed to be turned on when the resident was in bed for the night. The DOR was interviewed on 8/29/24 at 10:13 a.m. The DOR said Resident #5 required moderate assistance with transfers and short distance walks with his front-wheeled walker. The DOR said falls were discussed in morning meetings. He said Resident #5 was moved to the observation room on the second floor by the nurses station from the third floor after a couple of falls. He said the resident's falls were related to his poor cognition. He said the resident was unable to maintain not any safety education. The DOR said therapy focused on transfer training and safety and routine with the resident, but he worried about injury prevention. He said the therapy staff was working on fall recovery techniques with the resident. LPN #1 was interviewed on 8/29/24 at 10:0 a.m. LPN #1 said he was not aware of any specific fall prevention approaches for Resident #5, except frequent checks and call light within reach. He said there was no set time frame for frequent checks, it could be once every hour. IV. Director of nursing (DON) interview The DON was interviewed on 8/29/23 at 10:45 a.m. The DON said when a resident was accepted for admission, the admission coordinator screened for fall risk and notified the floor nurse to initiate fall prevention interventions. The DON said the 4 P's were the facility's fall prevention program, and every resident was at risk for falling. The DON said the admissions coordinator needed clinical credentials and he was unaware of how the admissions coordinator determined a resident's fall risk. The DON said a baseline care plan was developed for every resident at admission. The DON said the care plan was updated when a resident had a fall or required additional interventions. The DON reviewed the baseline care plans for Resident #30 and Resident #5 and said the interventions were the same because all residents were at risk for falls. He said the facility did not need to identify levels of fall risk because every resident was a fall risk, and the 4 Ps were used to prevent falls. The DON said CNAs should be aware of every resident at risk for falling by reviewing Resident task lists. He said CNAs were prompted for each resident when a resident had a fall, the care plan was updated, and CNAs were notified when they reviewed their assigned task list. -However, staff interviews revealed staff were not aware of which residents were fall risks and what fall interventions were in place for specific residents (see interviews above).

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interviews, the facility failed to provide effective pain management in accordance with professional standards for one (#1) of one resident out of 27 sample residents. Resident #1 was admitted on [DATE] with a diagnosis of intracerebral hemorrhage (stroke), type 2 diabetes, muscle weakness and adult failure to thrive. According to the 7/31/24 nursing comprehensive admission assessment for skin, Resident #1 had no skin issues. He often refused repositioning and to get out of bed due to pain. On 8/12/24 he developed pressure ulcers on his buttocks and coccyx. Additional medication was not ordered for wound care and all he was receiving for pain was Tylenol four times per day and a Lidocaine patch. On 8/27/24 Resident #1 was observed to be in severe pain during wound care of his buttocks and coccyx wounds. The facility's failure to provide effective pain management contributed to the resident suffering prolonged pain from his wounds and other areas on his body. Findings include: I. Facility policy and procedure The Pain Management policy and procedure, revised 2/8/21, was provided by the nursing home administrator (NHA) on 8/29/24 at 12:59 p.m. The policy read in pertinent part, Frequently, patients arrive from the hospital with acute pain secondary to being transferred to the facility. Once a patient expresses the perception of pain or makes a request for pain medications, the patient will be provided with a dose of analgesic pain medication or non-pharmacological interventions will be initiated. It is the responsibility of the individual or staff member that heard the complaint to follow up and make sure that some intervention (pharmacological or otherwise) is initiated. Nurses must follow pain parameters and enter pain scales for pain medications. II. Resident #1 A. Resident status Resident #1, age 79, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included intracerebral hemorrhage, type 2 diabetes, muscle weakness and adult failure to thrive. (continued on next page)

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	065413	A. Building B. Wing	08/29/2024

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The 7/31/24 minimum data set (MDS) assessment revealed the resident had no brief interview for mental status (BIMS) completed due to the resident rarely/never being understood. The nursing comprehensive assessment for the neurological system, completed on 7/31/24, revealed Resident #1 was alert and oriented to himself. The resident required extensive assistance from two or more staff members for bed mobility, transfers, dressing, toileting and personal hygiene. He was always incontinent of bowel and had an indwelling catheter in place. The MDS assessment indicated the resident did not receive scheduled pain medications. He received as needed pain medication and non-pharmacological interventions for pain. The pain assessment indicated the resident did not have pain. The resident had no skin conditions upon admission and was at risk for developing pressure ulcers. B. Resident interview Resident #1 was interviewed on 8/27/24 at 8:30 a.m. Resident #1 said he had pressure sores that caused him to be in a lot of pain all the time. He said he always laid right on the sores, which caused more pain. He said the nurses put a pain patch on his back or neck and he got Tylenol for the pain but it did not relieve the pain. He said he would like to get out of bed but it was too painful. He said it was too painful to lift up his legs. Resident #1 was interviewed a second time on 8/28/24 at 10:25 a.m. Resident #1 said the CNAs did not offer to get him out of bed. He said he would like to get out of bed and into his wheelchair. He said the female CNAs that came in and helped him were not strong enough to get him out of bed. He said it took three or four of them to get his brief changed. He said they needed a couple strong men to come and get him out of bed and this had never been offered. He said his legs and back were almost always in pain when he was moved. C. Observations and staff interviews During a continuous observation on 8/27/24, beginning at 1:54 p.m. and ending at 2:40 p.m., registered nurse (RN) #2 gathered supplies to complete wound care for Resident #1's wounds. She walked into the room and two unidentified certified nurse aides (CNA) were in the room providing incontinence care. Resident #1 was yelling out and said it hurt when they rolled him to his side. The unidentified CNAs were telling the resident they had to roll him in order to clean up his bottom because he had a bowel movement. Resident #1 said they needed to get strong men to come in and roll him because the girls in there were not strong enough. Resident #1 was pushing against the CNAs trying to roll him. RN #2 explained to Resident #1 the procedure she needed to do. Resident #1 agreed and RN #2 removed two bandages from Resident #1's coccyx and right side of his bottom. He yelled out and said that hurt. RN #2 cleansed the wounds with a wound cleanser and applied medication to the wounds. Resident #1 was screaming in pain during the treatment and asked her multiple times to stop because it was so painful. RN #2 said she was almost done and they had to clean the wounds. She applied the new bandages to the wounds. RN #2 said Resident #1 was pre-medicated with Tylenol prior to the wound care. She said the resident had a stage 3 pressure ulcer to his gluteal fold and a stage 3 pressure ulcer to his right buttocks with maceration (skin around the wound is softened from moisture exposure) around the wounds. (continued on next page)

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	065413	A. Building B. Wing	08/29/2024

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-RN #2 did not offer any pain interventions to Resident #1 during the wound care and did not stop wound care to give the resident a break when he was in pain. During a continuous observation on 8/28/24, beginning at 12:30 p.m. and ending at 1:30 p.m., the following was observed: CNA #5 was attempting to feed Resident #1 lunch. Resident #1 was refusing to eat. CNA #5 kept encouraging the resident to eat the chocolate ice cream while talking with him. He ate about ten bites. Resident #1 was talking about how much pain he was in. CNA #5 said she would tell the nurse about his pain after she fed him. During a continuous observation on 8/29/24, beginning at 12:15 p.m. and ending at 12:45 p.m. the following was observed: CNA #4 was assisting Resident #1 with his lunch. She sat him up in the bed and he yelled out to lay him back down. Resident #1 was yelling that it hurt when she sat him up. He told CNA #4 he did not want to eat because he was in so much pain. Resident #1 said if he was not in so much pain he would have liked to get up in his wheelchair. He said his back and bottom hurt. CNA #4 moved his left arm and he yelled out in pain. She said she was going to tell the nurse about his pain and come back to feed him later. D. Record review The 8/28/24 comprehensive pain evaluation (completed during the survey) revealed Resident #1 had pain frequently in his knees, back and neck. The pain frequently interfered with therapy. Resident #1 exhibited calling out, moaning and groaning when he experienced pain. The pain affected Resident #1's mood and functioning in his daily life. The assessment indicated rest, relaxation, diversion, elevation of extremities and immobilization provided him with relief. Necessary treatments that caused him pain included therapy and wound dressing changes. The assessment documented it was unable to be determined if the current pain program was working. The August 2024 CPO revealed the resident had the following physician's orders for pain management: -Lidocaine patch 4%, apply to neck and back topically every morning and at bedtime for discomfort/pain, apply patch in morning and remove at hour of sleep, ordered on 8/13/24. -Tylenol oral tablet 325 milligrams (mg), give two tablets by mouth four times a day for pain, ordered on 8/13/24. -Evaluation of pain every shift and document, ordered 7/31/24. (continued on next page)

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	065413	A. Building B. Wing	08/29/2024

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The care plan for acute/chronic pain, initiated on 7/31/24 and revised on 8/14/24, revealed the resident had chronic pain related to generalized chronic pain. Interventions for acute/chronic pain included acknowledging the presence of pain and discomfort, listening to the resident's concerns as needed, administering pain medications per physician's order and noting effectiveness, implementing non-pharmacological interventions when able, such as positioning/support, exercise/stretching, ice packs/moist hot pack application and relaxation, monitoring for pain every shift and as needed and notifying the physician as needed for any changes. According to the August 2024 (8/1/24 to 8/27/24) medication administration record (MAR), Resident #1 was offered repositioning and a calm environment for non-pharmacological pain interventions every four hours. -A review of Resident #1's electronic medical record (EMR) did not reveal the staff offered ice packs, moist hot packs, exercise/stretching or support to Resident #1 for non-pharmacological pain interventions. -A review of Resident #1's EMR did not reveal the staff were monitoring the effectiveness of Tylenol that was administered four times a day or the repositioning and calm environment. According to the turning and repositioning August 2024 CNA task log (8/1/24 to 8/26/24), Resident #1 was repositioned a total of 49 times. He was repositioned no more than two times a day. There were no refusals of repositioning documented on the log. III. Staff interviews CNA #4 was interviewed on 8/29/24 at 12:15 p.m. CNA #4 said Resident #1 refused to eat and be repositioned frequently. She said he yelled out in pain and verbalized pain often. She said every time this happened, she told the nurse. She said the nurse told her that they would check on him when this happened but she did not know what they did to address the problems. She said it helped to explain the procedures to him before they did anything because he was scared anything they did would make him hurt. CNA #5 was interviewed on 8/28/24 at 10:30 a.m. CNA #5 said Resident #1 was incontinent of bowel and bladder and was checked and changed every two hours or as needed. She said he often yelled when they cleaned him and repositioned him. She said he got confused but was redirectable. She said the staff had to explain what they were going to do to him before doing it. She said he never got out of bed. She said she was not sure why, but he would get up every now and then with therapy. She said they offered to reposition him every two hours and charted it in the computer system. She said she assisted the nurses with his wound care. She said each time she did this, he would scream out in pain during the wound care. RN #2 was interviewed on 8/28/24 at 11:40 a.m. RN #2 said Resident #1 was repositioned and checked and changed every one to two hours. She said he had pressure ulcers on his bottom. She said he had pain when he was moved for wound care and repositioning. She said he received Tylenol scheduled and Lidocaine patches for his back and neck. RN #2 said he did not get out of bed and she was not sure why. She said there was no reason he was bedbound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065413	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Cordera	9208 Grand Cordera Pkwy Colorado Springs, CO 80924

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F 0697 Level of Harm - Actual harm Residents Affected - Few	CNA #6 was interviewed on 8/28/24 at 12:10 p.m. CNA #6 said the CNAs repositioned Resident #1 every two hours and assisted him at every meal. She said he often refused to eat and be repositioned. She said therapy got him out of bed sometimes but he refused to get out of bed when the CNAs offered. She said he did not want them to hurt themselves because he thought they were too small and weak to get him up safely. She said he was always in pain and he flinched in anticipation before she touched him to perform resident care. She said she made sure to explain what she would be doing before she touched him. RN #3 was interviewed on 8/29/24 at 12:00 p.m. RN #3 said Resident #1 had pain primarily with movement and when he was repositioned. He said the pain was mainly in his neck. He said he received scheduled Tylenol and Lidocaine patches for the pain. He said he documented Resident #1's pain level before administration of the Tylenol and every shift. He said non-pharmacological interventions to address pain included ice and heat packs but he never got these for the resident. RN #3 said therapy sometimes got the non-pharmacological pain interventions for the resident. He said the CNAs reported to him when the resident was having pain and he would go and check on the resident. He said he was not aware of Resident #1 refusing care due to pain. He said the Tylenol and patches helped the resident's pain. The director of nursing (DON) was interviewed on 8/29/24 at 10:00 a.m. The DON said Resident #1 was at risk for developing pressure ulcers at admission. He said on admission, Resident #1 was refusing care and could become aggressive with staff. He said Resident #1 was sleepy when he was admitted so the provider discontinued his pain medications. He said Resident #1 did experience pain in his neck and back. He said he got scheduled Tylenol and Lidocaine patches. He said he was not sure if the medications relieved the resident's pain.

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	065413	A. Building B. Wing	08/29/2024

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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** 50315 Based on observations, record review and interviews, the facility failed to establish a sanitary environment to help prevent the transmission of communicable diseases and infections on one of five hallways. Specifically, the facility failed to: -Ensure the housekeeping staff completed proper hand hygiene when cleaning resident rooms and followed the appropriate guidelines for disinfectant solution; and, -Ensure the nursing staff followed enhanced barrier precautions (EBP) appropriately during resident care. Findings include: I. Failure to ensure housekeeping completed proper hand hygiene and followed appropriate disinfectant guidelines when cleaning resident rooms A. Professional reference The Center for Disease Control (CDC) (February 2024) Clinical Safety: Hand Hygiene for Healthcare Workers, was retrieved on 9/4/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html. It read in pertinent part, Recommendations to clean your hands include immediately before touching a patient, before performing an aseptic technique, before moving from work on a soiled body site to a clean body site, after touching a patient or patient's surroundings, after contact with body fluids and immediately after glove removal. The 730 hp disinfectant cleaner manufacturer label was retrieved on 9/5/24 from https://picol.cahnrs.wsu.edu/Download/LabelByLegacyPath?legacyPath=/~picol/pdf/WA/66222.pdf It read in pertinent part, For use as a daily one-step cleaner/disinfectant: dilute at two ounces of product per gallon of water, pre-clean heavily soiled surfaces, apply use solution by coarse trigger sprayer to hard surfaces, spray six to eight inches from surface making sure to wet surfaces thoroughly, all surfaces must remain wet for ten minutes, wipe surfaces and let air dry. B. Facility policy and procedure The Hand Hygiene policy and procedure, revised 1/7/24, was received from the nursing home administrator (NHA) on 8/29/24 at 12:59 p.m. It documented in pertinent part, Use soap and water when hands become dirty or soiled. Use an alcohol-based hand sanitizer that contains at least 60% alcohol. Put enough sanitizer on your hands to cover all surfaces, rub your hands together until they feel dry. C. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 8/27/24, beginning at 10:00 a.m. and ending at 11:08 a.m., the following was observed: Housekeeper (HSKP) #1 was observed cleaning resident room [ROOM NUMBER]. She finished mopping the room and removed her dirty gloves. Without performing hand hygiene, she donned (put on) clean gloves. HSKP #1 moved to room [ROOM NUMBER]. She started cleaning the bathroom by spraying 730 hp disinfectant solution on the sink. She immediately wiped the sink with a towel. She sprayed the grab bars in the bathroom with the disinfectant and immediately wiped them down with a towel. She repeated this process with the toilet. She mopped the bathroom. She removed the dirty gloves, and without performing hand hygiene, she donned clean gloves. She moved to the bedroom and sprayed the bedside table with 730 hp disinfectant solution. She immediately wiped down the surface with a towel. She repeated this process with the window sill and the desk. She mopped and swept the floor. -HSKP #1 did not follow the correct dwell time for the 730 hp disinfectant solution. -HSKP #1 did not perform hand hygiene in between glove changes. HSKP #1 moved to room [ROOM NUMBER]. She sprayed the door handles with 730 hp disinfectant solution and immediately wiped them down with a towel. She repeated this process with the sink in the bathroom, the toilet and the commode. She mopped the bathroom and removed the dirty gloves. Without performing hand hygiene, she donned clean gloves. She sprayed the bedside table with 730 hp disinfectant solution and immediately wiped it down with a new rag. She repeated this process with the window sill and desk. She mopped the room. She removed the dirty gloves. Without performing hand hygiene, she began to wipe down the window sill in the hallway. -HSKP #1 did not follow the correct dwell time for the 730 hp disinfectant solution. -HSKP #1 did not perform hand hygiene in between glove changes. D. Staff interviews The housekeeping director (HSKD) was interviewed on 8/28/24 at 4:06 p.m. The HSKD said the dwell time for the 730 hp disinfectant solution was one minute for cleaning their standard rooms with no transmission based precautions. He said hand hygiene should be completed after removing dirty gloves and prior to donning clean gloves. -However, the 730 hp disinfectant solution manufacturer label indicated the dwell time was 10 minutes. The director of nursing (DON) was interviewed on 8/29/24 at 10:00 a.m. The DON said hand hygiene should be performed after removing dirty gloves. He said hand hygiene should be performed prior to donning clean gloves. (continued on next page)

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	065413	A. Building B. Wing	08/29/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Failure to ensure nursing staff followed enhanced barrier precautions (EBP) appropriately during resident cares A. Facility policy and procedure The Enhanced Barrier Precautions policy and procedure, issued 3/27/24, was received from the NHA on 8/29/24 at 12:59 p.m. It documented in pertinent part, Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce the number of multidrug resistant organisms that employs targeted gown and glove use during high-contact resident care activities. EBP are required for patients with wounds and/or indwelling medical devices. High-contact care activities included dressing, bathing, transferring, working with patients in the therapy gym, providing hygiene, changing linens, changing briefs or assisting with toileting, device care and wound care. B. Observations During a continuous observation, beginning on 8/27/24 at 10:00 a.m. and ending at 11:08 a.m, the following was observed: An unidentified certified nursing assistant (CNA) entered into room [ROOM NUMBER] after an unidentified transportation staff member assisted the resident to his room after the resident returned from a doctor's appointment. He had an indwelling foley catheter device and was on EBP. There was a sign posted outside the room and a cart that contained gowns and gloves outside his door. The unidentified CNA donned clean gloves and walked into the room. She transferred the resident from his wheelchair to his bed using a gait belt. The unidentified CNA moved the catheter drainage bag from the wheelchair and hooked it onto the bottom of his bed. She walked out of his room and removed the dirty gloves. She washed her hands. -The CNA did not put a gown on to provide resident care to a resident on EBP. During an observation on 8/28/24 at 3:17 p.m., the following was observed: The resident in room [ROOM NUMBER] initiated his call light . The staffing coordinator (SC) walked into the room. She grabbed gloves on her way into the room. There was a sign on the door that indicated the resident was on EBP. There was a cart stocked with gowns and gloves outside his room. She asked how she could help him and he asked to get out of bed. She put a gait belt on him and assisted him out of bed and into a wheelchair. She moved his catheter drainage bag from the bed to his wheelchair. She removed her gloves and washed her hands. -The SC did not wear a gown when she assisted the resident with transferring and when handling a resident who had a foley catheter that was on EBP. C. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Cordera	9208 Grand Cordera Pkwy Colorado Springs, CO 80924

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 DON was interviewed on 8/29/24 at 10:00 a.m. The DON said EBP should be followed when providing resident care for those with medical devices or chronic wounds. He said high contact activity included when the staff members were in direct contact with the resident. He said some of these activities included toileting residents, changing linens, dressing residents, transferring residents and providing wound care. He said staff should put a gown and gloves on prior to providing these care activities with residents on EBP.