STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065424	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Rehabilitation and Healthcare Center	1335 6th St Del Norte, CO 81132

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on observations, record review and interviews, the facility failed to promote and maintain the resident's dignity for four (#3, #39, #49 and #51) of five residents reviewed for dignity and respect out of 41 sample residents. Specifically, the facility failed to ensure Resident #3, Resident #39, Resident #51 and Resident #49's call lights were in reach. Findings include: I. Facility policy and procedure The Call System policy, dated September 2022, was provided by the nursing home administrator (NHA) on 12/19/24 at 2:07 p.m. It read in pertinent part, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan. Answering the Call Light procedure, revised September 2022, was received by the NHA on 12/19/24 at 9:03 a.m. It read in pertinent part, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. II. Resident #3 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #3, age greater than 65, was initially admitted on [DATE] and readmitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included chronic respiratory failure (a long term condition that prevents the body from exchanging oxygen and carbon dioxide properly) and dementia. The 12/6/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out of 15. She was dependent on staff for assistance with toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS assessment documented the resident had an impairment on one side of her upper extremity. She had impairment on both sides for lower extremities. B. Observation On 12/17/24 at 1:17 pm Resident #3 called out and asked could you please hand me my call light. Resident #3 was seated in her bedside chair and her call light was on the bed and out of reach. C. Record review The activity of daily living (ADL) care plan, revised 6/30/24, documented Resident #3 had an ADL self-care performance deficit related to cognitive impairments, history of falls and impaired mobility. Interventions included: encouraging the resident to use her call light when assistance was needed and placing call light within reach. The care plan for falls, revised 9/11/24, documented Resident #3 was at risk for falls related to a history of falls. Interventions included: educating the resident and the family to call for assistance before transferring, ensuring the call light was within reach, educating the resident to use call light and ensuring needed items within reach. III. Resident #39 A. Resident status Resident #39, age greater than 65, was initially admitted on [DATE] and readmitted on [DATE]. According to the December 2024 CPO, diagnoses included chronic kidney disease stage four, Alzheimer's disease and dementia. The 10/28/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of six out of 15. She required supervision or touching assistance with eating, oral hygiene, toileting hygiene, upper body dressing, putting on/taking off footwear and personal hygiene. B. Observations and resident interview On 12/16/24 at 3:24 p.m. Resident #39's call light was located on the floor between her recliner chair and bed. The call light was out of reach for Resident #39. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/24 at 9:38 a.m. Resident #39's call light was located on the floor between her recliner chair and bed. On 12/18/24 at 4:28 p.m. Resident #39's call light was on the floor between her recliner chair and bed. On 12/19/24 at 9:50 a.m. Resident #39 said she did not know where her call light was at. She said if she needed any help she would get up and ask for help. C. Record review The care plan for ADL, revised 7/18/24, documented Resident #39 had ADL self-care performance deficit related to dementia and hypoxia. Interventions included: encouraging the resident to use her call light when assistance was needed and placing assistive devices within reach. IV. Resident #49 A. Resident status Resident #49, age 65, was initially admitted on [DATE] and readmitted on [DATE]. According to the December 2024 CPO, diagnoses included ataxic gait (a type of walking characterized by an inability to coordinate movements, resulting in an awkward, unsteady and wide based gait), traumatic brain injury and depression. The 11/20/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was dependent on staff assistance with eating, oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS assessment documented the resident had impairment on both sides for upper and lower extremity. B. Observations and resident interview Resident #49 was interviewed on 12/16/24 at 4:28 p.m. Resident #49's call light was placed in his dresser drawer next to his bed. Resident #49 said he was not able to reach his call light. He said half of the time he did not know where his call light was at. He said he was not able to reach his call light in his drawer. Resident #49 was interviewed on 12/18/24 at 4:25 p.m. Resident #49's call light was clipped to the side of his bed. Resident #49 said he did not know where his call light was and said he could not reach the side of his bed. Resident #49 was interviewed on 12/19/24 at 9:33 a.m. Resident #49 said when he was not able to reach his call light made him feel helpless. He said when he was not able to reach his call light that he would call out for help. He said he has had to yell for help once to twice a day. He said he did not like to yell for help and said he wanted his call light to be within reach. C. Record review (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADL care plan, revised 9/4/24, documented Resident #49 had ADL self-care performance deficit. Interventions included: encouraging the resident to use call light when assistance was needed, placing assistive devices within reach and placing call light within reach. V. Resident #51 A. Resident status Resident #51, age greater than 65, was initially admitted on [DATE] and readmitted on [DATE]. According to the December 2024 CPO, diagnoses included respiratory failure, depression and dementia. The 12/13/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of six out of 15. She required substantial/maximal assistance with toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. B. Observation On 12/16/24 at 4:09 p.m. Resident #51's call light was on the floor by the foot of the resident's bed. Resident #51 was sitting in her wheelchair. C. Record review The ADL care plan, revised 7/1/24, documented Resident #51 had ADL self-care performance deficit related to weakness from prolonged hospital stay due to COVID-19, pneumonia. Interventions included: allowing time for the resident to express feelings of frustration regarding the need for assistance in ADL tasks, encouraging the resident to use call light when assistance was needed, placing assistive devices within reach and placing call light within reach. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 12/19/24 at 10:02 a.m. CNA #1 said the call lights should be placed within reach for all residents. CNA #1 said the call lights should be clipped onto the residents bed or sheet, within the residents reach. CNA #1 said all staff were responsible for making sure the call lights were within reach of the residents. She said every time a staff member went in to check on a resident, the staff member should ensure the call light was within reach. She said the call lights should never be out of reach for residents. CNA #1 said the call lights should not be on the floor. CNA #1 said if residents could not hold the call light that she would use clips to clip the call light close to them. She said if she saw the call light on the floor she would pick it up and place the call light within reach. Licensed practical nurse (LPN) #1 was interviewed on 12/19/24 at 10:12 a.m. LPN #1 said the call lights should be placed near the residents so they could grab it. She said every one that came into contact with residents should make sure call lights were within reach. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 said the call lights should not be on the floor because they could be contaminated. LPN #1 said if the call lights were not within reach, the resident could not call for help. She said the call lights should not be out of reach for residents with limited range of motion because they could not call for help if they need anything. The director of nursing (DON) and the NHA were interviewed together on 12/19/24 at 10:19 a.m. The DON said the call lights should always be placed within the residents reach. The DON said the residents used their call lights to call for assistance. The DON and the NHA said all of the staff were responsible for ensuring the call lights were within reach of the residents. The DON said the call lights should never be on the floor. She said if the call light was not within reach that it should be addressed right away and placed within reach. She said call lights should always be in reach.

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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** 47536 Based on record review and interviews, the facility failed to ensure that all residents were free from abuse, neglect, and exploitation for one (#53) of three residents reviewed for abuse out of 41 sample residents. Specifically, the facility failed to protect Resident #53 from verbal abuse by certified nurse aide (CNA) #7. Findings include: I. Facility policy and procedure The Abuse Prevention policy, revised March 2018, was provided by the nursing home administrator (NHA) on 12/17/24 at 3:10 p.m. It read in pertinent part, The physician and staff will help identify risk factors for abuse in the facility, for example, issues related to staff knowledge and skill, or performance that might affect resident care. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The management and staff will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. II. Facility investigation of the abuse allegation involving Resident #53 and CNA #7 on 8/8/24 The facility's investigation of the allegation of physical abuse between Resident #53 and CNA #7 on 8/8/24 documented the following: The investigation report read that after a shower Resident #53 was observed crying in the sunroom. The facility started an investigation immediately and the police were notified 8/8/24 at 11:00 a.m. The investigation report documented Resident #53 denied verbal or physical abuse occurred and was hesitant to answer questions asked by the police investigator. The investigation report, dated 8/8/24, documented that licensed practical nurse (LPN) #2 heard CNA #7 tell Resident #53 Stop (expletive word) crying. LPN #2 reported Resident #53 was observed crying during the occurrence. CNA #8 reported she observed CNA #7 make Resident #53 take a shower when Resident #53 did not want a shower and she heard CNA #7 tell Resident #53, (Expletive word) you, you piece of (expletive word) and Do not start with me. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 the facility interviewed Resident #53's previous roommate. The documentation revealed the roommate reported he heard CNA #7 joking around, exchanging words, and hollering between CNA #7 and Resident #53. The roommate reported he heard CNA #7 tell Resident #53 he would take a shower regardless and the roommate said he was afraid that CNA #7 might cut Resident #53 while helping him shave for reporting his feelings. On 8/8/24 the facility interviewed six current residents and two family members of residents in the facility. The documentation revealed no residents or family members reported they had been treated roughly or rudely or yelled at by staff or others. None of the residents or the family members reported feeling afraid because of the way some other resident was treated. On 8/8/24 the facility interviewed two current employees. The documentation reviewed the employees had no concerns about the care provided by CNA #7. On 8/8/24 the facility completed 14 random skin assessments of current residents in the facility. There were no concerns identified during the random skin assessments. CNA #7 was placed on suspension on 8/8/24 pending the facility's investigation of the incident and terminated on 8/16/24. The facility required all staff to complete abuse training, prevention and reporting during new hire orientation and staff received ongoing education on abuse prevention at staff meetings and individually as needed. Resident #53 was monitored following the incident for any behaviors related to the incident. III. Resident #53 A. Resident status Resident #53, age 65, was admitted on [DATE]. According to the December 2024 computerized physician's orders (CPO), diagnoses included right side paralysis, history of stroke and depression. The 10/18/24 minimum data set (MDS) assessment revealed the resident had moderately impaired cognition with a brief interview for mental status (BIMS) score of ten out of 15. The resident was dependent on staff for transfers, showers, and toileting and required assistance from staff for showers or bathing. The resident did not walk and used a manual wheelchair to get around the unit with assistance from staff. The assessment documented the resident had no verbal, physical, or behavioral symptoms directed towards others. The resident had no history of rejecting care. B. Resident interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53 was interviewed on 12/17/24 at 9:25 a.m. Resident #53 said that CNA #7 forced him to take a shower when he declined. He said CNA #7 yelled at him and made him feel afraid and sad and tearful after the shower. Resident #53 said CNA #7 was also his son. and he no longer worked at the facility. Resident #53 said when his son came to visit they spent time together in the common area sunroom or in a table area at the end of a hallway. Resident #53 said his son did not yell at him during the visits and he enjoyed the visitations with his son. C. Record review The nurse progress note dated 8/8/24 at 4:54 p.m. documented the NHA observed Resident #53 crying in the front lobby of the facility and the NHA initiated an investigation. IV. Staff interviews -LPN #2 and CNA #8 (who witnessed the incident on 8/8/24) were not available for interviews during the survey. CNA #3 was interviewed 12/17/24 at 9:25 a.m. CNA #3 said she was familiar with Resident #53 and knew about the incident between Resident #53 and CNA #7. CNA #3 said she had not noticed Resident #53 with any mood or behavior changes following the incident. CNA #3 said she had received education on abuse prevention during her CNA school and from the facility when she was hired. CNA #3 said she had no concerns about abuse of residents or staff in the facility. The NHA was interviewed on 12/17/24 at 10:50 a.m. The NHA said on 8/8/24 she noticed Resident #53 crying as he sat in the sunroom area. The NHA said she followed facility policy and initiated an investigation. The NHA said Resident #53 denied verbal abuse but two staff members witnessed and reported the verbal abuse toward Resident #53. The NHA said CNA #7 was suspended immediately on 8/8/24 and terminated on 8/16/24. The NHA said the facility monitored Resident #53 for signs or symptoms of post-traumatic stress disorder (PTSD) following the incident and no changes in the resident occurred. The NHA said after the incident, the facility completed interviews with staff and other residents and completed skin assessments on other residents CNA #7 care for. The NHA said there were no concerns identified. The NHA said staff received education on abuse prevention during new-hire orientation and at other times, such as during staff meetings or morning huddle meetings, and as needed. The NHA said staff were educated to identify and report concerns of abuse or neglect immediately. The NHA said CNA #7 was also the son of Resident #53. She said Resident #53 wanted his son to continue to be allowed to visit him periodically in the facility. The NHA said the facility had a safety plan for visitation that required visits between Resident #53 and his son (CNA #7) to be in common areas and in the line of sight of other staff members. The NHA said there had been no concerns of abuse identified or changes to the resident's mood after visits with his son.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interview, the facility failed to ensure one (#4) of three residents out of 41 sample residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. Specifically, the facility failed to follow the physician's orders for Resident #4's pain medications and dressing changes. I. Facility policy and procedure The Administering Medications policy, revised April 2019, was provided by the nursing home administrator (NHA) on 12/19/124 at 9:03 a.m. It read in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the medication administration record space provided for the drug and dose. II. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician order (CPO) diagnoses included heart failure, osteoarthritis and osteoporosis. The 8/19/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The 11/17/24 MDS assessment revealed she was on a pain medication regimen and received non-medication interventions for pain. She had pain in the past five days. She received skin treatments that included application of ointments and medications. The assessment revealed the resident did not reject care. B. Resident interview and observations Resident #4 was interviewed on 12/16/24 at 2:02 p.m. Resident #4 was in a wheelchair next to an over the bed table. She had ted hose on both lower extremities. She said she had pain in her hips, her knees and her shins. Resident #4 said she had bandages on her lower extremities because she went to the hospital four days ago because her legs were leaking. She was not sure what caused the leaking but she thought it was because she had heart disease. C. Record review (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the October 2024 CPO revealed the following physician's orders for pain management: -Lidocaine external patch four percent, apply to the left hip topically in the morning for pain, ordered 3/4/24. -Lidocaine external patch four percent, apply to the right buttock topically in the morning for pain, ordered 3/4/24. A review of the October 2024 medication administration record (MAR) revealed the lidocaine external patch four percent was not administered to the left hip and to the right buttock on 10/2/24, 10/3/24, 10/4/24, 10/5/24, 10/6/24, 10/7/24, 10/8/24, 10/9/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/14/24, 10/15/24, 10/16/24, 10/17/24, 10/18/24 and 10/19/24. The October 2024 progress notes revealed the lidocaine external patch was not administered on to the left hip and to the right buttock from 10/2/24 to 10/19/24 because the medication was not available. -However, a review of the resident's electronic medical record (EMR) revealed there was no documentation the provider was notified the medication was not available and there was no documentation why the medication was not available. A review of the December 2024 CPO revealed the following physician's orders for wound care: -Daily dressing change to the right lower extremity for weeping edema, cleanse area, apply telfa (wound dressing), ABD pad and ace wrap, check the area every two hours, order until symptoms resolve, one time a day for weeping edema to the right lower extremity, ordered 12/6/24 and discontinued 12/12/24. A review of the December 2024 MAR revealed the daily dressing change to the resident's right lower extremity was not completed on 12/6/24, 12/9/24 and 12/11/24. The December 2024 progress notes revealed the dressing change was not completed on 12/6/24, 12/9/24 and 12/11/24 because the site was healed. -However, a review of the resident's electronic medical record revealed there was no documentation the provider was notified the site was healed. D. Staff interviews Certified nurse aide with medication authority (CNA-Med) #1 was interviewed on 12/18/24 at 9:23 a.m. CNA-Med #1 said she knew a resident was in pain based on facial expressions and if the resident told her verbally. She said she told a nurse if she knew the resident was in pain. CNA-Med #1 said Resident #4 had pain mostly in her back and in her right knee. CNA-Med #1 said Resident #4 recently had pain more frequently. She said Resident #4 had the pain because she had sciatica and arthritis. CNA-Med #1 said pain medication and lidocaine patches helped with her pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA-Med #1 said if a medication was not available in the medication cart, she would see if there was any available in the central supply closet. She said if there was not any available, she would notify the nurse. CNA-Med #1 did not know why Resident #4 did not have lidocaine patches in October 2024 and did not know why the dressing changes were not done. The director of nursing (DON) was interviewed on 12/18/24 at 4:01 p.m. The DON said if a wound was healed, the nurse should look at the order The DON said the nurse should look at the order because sometimes the provider said to discontinue the treatment when the wound was healed. The DON said if the order did not have orders to discontinue when healed, the nurse should contact the provider and monitor the site for symptoms. The DON did not know why Resident #4 dressing administration record showed it was healed on some days and why it was completed on the other days. The DON said the wound was healed. The DON said if a medication was not available, the nurse checked the central supply closet. She said if there was no medication available in the central supply closet, the nurse should reorder and contact the provider. The DON said she was not in her current position when the lidocaine was not administered for Resident #4. The DON and the NHA were interviewed together on 12/19/24 at 9:34 a.m. The DON said she reviewed the dressing orders for Resident #4. The DON said the orders should have been more clear. The DON and the NHA said there should have been one order to administer dressing changes and one order to monitor the site. The NHA said she did not know why the lidocaine patches were not administered in October 2024 for 18 days. She said it could have been an insurance issue or it could have been an availability issue. She said the nurse should have contacted the provider if the medication was not administered. The NHA said the nurse should have had a progress note on why the medication was not administered and the provider was notified. The NHA said the provider needed to be contacted to see if it was ok to hold the medication, change the order or some other direction. The NHA said they had access to go to a local pharmacy and to a retail pharmacy. The NHA said the facility should not have waited and found a way for the resident to have her medication.

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NAME OF PROVIDER OR SUPPLIER River Valley Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1335 6th St Del Norte, CO 81132	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure meals were served according to the resident's preferences for one (#12) of two residents out of 41 sample residents. Specifically, the facility failed to offer food choices according to Resident #12's preferences. Findings include: I. Facility policy and procedure The Food Preparation and Serving policy, undated, was provided by the nursing home administrator (NHA) on 12/19/124 at 9:03 a.m. It read in pertinent part, Special care is given when purchasing food to select fresh food when possible. Between meals and bedtime snacks are offered. These snacks are of a nutritious quality. II. Resident #12 A. Resident status Resident #12, age less than 65, was admitted on [DATE]. According to the December computerized physician orders (CPO) diagnoses included type 2 diabetes mellitus, cerebral infarction (stroke), hemiplegia (paralysis on one side) and hemiparesis (weakness or inability to move one side of the body), chronic obstructive pulmonary disease (COPD), epilepsy (seizure disorder), depressive episodes and anxiety. The 9/10/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The 7/19/24 MDS assessment revealed it was very important to have snacks available between meals. It revealed the resident had an obvious or likely cavity or broken natural teeth. B. Resident interview and observation Resident #12 was interviewed on 12/16/24 at 2:52 p.m. He said he liked grapes as a snack and the facility had been out of grapes for a long time. He said it was frustrating the dietary department was not trying to find an alternative. He said he did not like bananas and apples were too hard to eat because of his teeth. Resident #12 said if he was the dietary manager (DM) and he was out of something, he would find an alternative or go to the grocery store right that was next door to see if they had grapes. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview, dietary aide (DA) #1 walked into Resident #12's room. She offered the resident a chocolate cookie and a chex mix snack. Resident #12 asked for grapes and DA #1 said she did not have grapes. C. Record review The nutrition care plan, revised 7/30/24, revealed the resident was at risk for altered nutritional status related to obesity, gastroesophageal reflux disease (GERD), diabetes and edema. Interventions included keeping the resident's food preferences up to date and providing meals, snacks and fluids. The 8/19/24 nutritional risk assessment revealed the residents liked sweets, sweet tea, chips, fruit loops, peanut butter, grapes, corn, jello and pork. D. Observations On 12/18/24 at 11:10 a.m. during a kitchen tour, grapes were not observed in the kitchen. E. Staff interviews On 12/17/24 at 2:54 p.m., DA #1 was in the F hallway with a snack cart. She said she had chips, [NAME] butter cookies and chocolate cookies to offer residents as a snack. She said she should offered the residents chips, [NAME] butter cookies, cookies, yogurt, pudding and fruit. She said she had yogurt in the kitchen. DA #1 said she did not have fresh fruit to offer and she was not sure if pudding was currently available. DA #1 was familiar with Resident #12 and she said he always asked for grapes. The DM was interviewed on 12/18/24 at 2:53 p.m. She said she started as the DM on 12/16/24. She said she had worked at the facility since July 2024. She said she was responsible for obtaining the resident's food preferences. She said she has not been trained on how and when to obtain the resident's preference. The DM said snacks were offered to all residents. The DM said residents prescribed a pureed diet were offered pudding, apple sauce and pureed cake. She said the three types of pudding were vanilla, butterscotch and lemon. She said residents loved butterscotch and she had been out of butterscotch pudding for the past three days. She said residents prescribed a regular diet were offered chips, cookies, chex mix, goldfish, sandwiches, fruit cups, yogurt and [NAME] butter cookies. She said residents prescribed a diabetic diet were offered chips, goldfish, sugar free applesauce, broccoli and ranch, and celery with peanut butter. The DM said the residents knew what snacks were offered because the DAs had the cart with them when they went room to room. She said the list of snacks was not posted in the resident's room but she planned to have the list available so the residents knew what snacks were available. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DM said the previous DM did not order enough snacks for the residents. The DM said the facility did not have enough snacks for the residents since she started\. She said there were times when the facility was out of chips for a week or out of peanut butter for three days. She said the residents loved peanut butter and jelly sandwiches. The DM said there was no reason to not go to the store. She said she went to the store today to get an item for lunch. The DM said Resident #12 liked nacho tortilla chips, chex mix, pudding, gummy bears and grapes. The DM said he often refused dinner and wanted grapes. The DM said he liked vanilla and chocolate pudding. The DM said the facility has not had grapes for a while. She said the previous DM did not order grapes. The DM said she had not been trained on placing the food order, so the facility was currently receiving orders based on the previous DM's order list. She said that list did not include grapes. The DM said it was important to have snacks residents liked because the facility was their home. She said if the dietary staff knew a resident had a bad day the staff could offer food the resident liked. She said it was also important to offer the residents food they liked because the residents would be upset if they had to tell the dietary staff what they liked.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47350 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection in one of four units. Specifically, the facility failed to ensure glucometers were cleaned in a sanitary manner. I. Professional reference The Centers for Disease Control and Prevention (CDC) Considerations for Blood Glucose Monitoring and Insulin Administration (8/7/24), was retrieved on 12/27/24 from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html#:~:text=Unsafe%20practices%20during%20assisted%20monitoring,for%20more%20than%20one%20person. It read in pertinent part, Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus, hepatitis C virus, human immunodeficiency virus (HIV) and other infections. Unsafe practices include: using fingerstick devices for more than one person, using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses. II. Facility policy and procedure The Capillary Blood Sampling policy and procedure, reviewed September 2014, was provided by the nursing home administrator (NHA) on 12/19/24 at 9:03 a.m. It read in pertinent part, Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. III. Manufacturer's recommendations The Arkray Assure Platinum Blood Glucose Meter manufacturer cleaning and disinfecting guidelines, 2024, were retrieved on 12/27/24 at 1:17 p.m. from https://arkrayusa.com/diabetes-management/professional-healthcare-products/assure/assure-platinum. It read in pertinent part, The Assure Platinum blood glucose meter may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedure are followed. The meter should be cleaned and disinfected after use on each patient. Disinfecting the meter can be accomplished with an environmental protection agency (EPA) registered disinfectant detergent or germicide that is approved for healthcare settings or a solution of 1:10 concentration of sodium hypochlorite (bleach). Each time the cleaning and disinfecting procedure is performed two wipes are needed. One wipe to clean the meter and a second wipe to disinfect the meter. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Rehabilitation and Healthcare Center	1335 6th St Del Norte, CO 81132

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Super Sani Cloth Germicidal Disposable Wipe manufacturer guidelines, 2024, were retrieved on 12/27/24 from https://pdihc.com/products/environment-of-care/super-sani-cloth-germicidal-disposable-wipe. It read in pertinent part, Bactericidal, Tuberculocidal, Virucidal and Fungicidal. Overall contact time is two minutes. IV. Observations On 12/18/24 at 11:15 a.m. registered nurse (RN) #1 took an unlabeled glucometer out of the medication cart. She went to Resident #11's room and used the glucometer to obtain the resident's blood glucose level. She returned to the medication cart, wiped off the blood glucometer with one Super Sani Cloth germicidal wipe and let the glucometer dry. -RN #1 did not use two wipes to clean and disinfect the meter (see manufacturer's recommendations above). -RN #1 did not leave the glucometer wet for the two minute disinfection time (see manufacturer's recommendations above). On 12/18/24 at 11:25 a.m. RN #1 took the same unlabeled glucometer from the medication cart and used it to obtain a blood glucose level from Resident #13. She then returned to the medication cart with the blood glucometer and wiped the glucometer with one Super Sani Cloth germicidal wipe and let the glucometer dry. -RN #1 did not use two wipes to clean and disinfect the meter (see manufacturer's recommendations above). -RN #1 did not leave the glucometer wet for the two minute disinfection time (see manufacturer's recommendations above). V. Record review Review of the 10 residents in the facility who received blood glucose checks with a glucometer, completed on 12/18/24, revealed there were no residents with a diagnosis for a transmittable blood-borne disease. VI. Staff interviews RN #1 was interviewed on 12/18/24 at 11:30 a.m. RN #1 said that her practice after wiping the glucometer with a Super Sani Cloth germicidal wipe was to immediately let the glucometer dry. She said she did not know the disinfection time of the Super Sani Cloth wipes or how long the glucometers needed to stay wet after they were cleaned and disinfected. She said it was important to clean glucometers correctly to prevent the spread of blood-borne pathogens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 12/18/24 at 11:35 a.m. The NHA said nursing staff should be cleaning and disinfecting the glucometers according to the manufacturer's recommendations to ensure the glucometer was appropriately disinfected for blood-borne pathogens. She said the glucometer manufacturer's recommendations on how to clean the blood glucometers would be reviewed with the nursing staff. She said the facility would ensure residents had their own designated glucometers so glucometers were not shared between residents.