

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
NAME OF PROVIDER OR SUPPLIER River Valley Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114</p> <p>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.</p> <p>Specifically, the facility failed to ensure Resident #3, Resident #39, Resident #51 and Resident #49's call lights were in reach.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident.</p> <p>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.</p> <p>II. Resident #3</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A. Resident status</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>B. Observation</p> <p>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.</p> <p>C. Record review</p> <p>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.</p> <p>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.</p> <p>III. Resident #39</p> <p>A. Resident status</p> <p>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.</p> <p>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.</p> <p>B. Observations and resident interview</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>On 12/18/24 at 4:28 p.m. Resident #39's call light was on the floor between her recliner chair and bed.</p> <p>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.</p> <p>C. Record review</p> <p>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.</p> <p>IV. Resident #49</p> <p>A. Resident status</p> <p>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.</p> <p>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.</p> <p>The MDS assessment documented the resident had impairment on both sides for upper and lower extremity.</p> <p>B. Observations and resident interview</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>C. Record review</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>V. Resident #51</p> <p>A. Resident status</p> <p>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.</p> <p>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.</p> <p>B. Observation</p> <p>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.</p> <p>C. Record review</p> <p>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.</p> <p>D. Staff interviews</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536</p> <p>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.</p> <p>Specifically, the facility failed to protect Resident #53 from verbal abuse by certified nurse aide (CNA) #7.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>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,</p> <p>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.</p> <p>The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.</p> <p>The management and staff will address situations of suspected or identified abuse and report them in a timely manner</p> <p>to appropriate agencies, consistent with applicable laws and regulations.</p> <p>II. Facility investigation of the abuse allegation involving Resident #53 and CNA #7 on 8/8/24</p> <p>The facility's investigation of the allegation of physical abuse between Resident #53 and CNA #7 on 8/8/24 documented the following:</p> <p>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.</p> <p>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</p> <p>Do not start with me.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>CNA #7 was placed on suspension on 8/8/24 pending the facility's investigation of the incident and terminated on 8/16/24.</p> <p>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.</p> <p>Resident #53 was monitored following the incident for any behaviors related to the incident.</p> <p>III. Resident #53</p> <p>A. Resident status</p> <p>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.</p> <p>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.</p> <p>The assessment documented the resident had no verbal, physical, or behavioral symptoms directed towards others. The resident had no history of rejecting care.</p> <p>B. Resident interview</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>C. Record review</p> <p>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.</p> <p>IV. Staff interviews</p> <p>-LPN #2 and CNA #8 (who witnessed the incident on 8/8/24) were not available for interviews during the survey.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p>47536</p> <p>Based on record review and interviews, the facility failed to ensure residents received care from qualified employees for 11 (#15, #5, #46, #49, #34, #6, #19, #262, #45, #47 and #24) of 11 residents out of 41 sample residents.</p> <p>Specifically, the facility failed to ensure qualified and credentialed staff received, entered, confirmed and revised verbal and written physician's orders for Residents #15, #5, #46, #49, #34, #6, #19, #262, #45, #47 and #24.</p> <p>Findings include:</p> <p>I. Record review</p> <p>A. Resident #15</p> <p>Review of Resident #15's December 2024 computerized physician orders (CPO) revealed the following physician's orders:</p> <p>Tylenol, give as needed every eight hours, not to exceed three grams of tylenol in 24 hours, ordered 2/1/23.</p> <p>-The physician's order was created and confirmed by the medical records assistant (MRA).</p> <p>Shortness of breath while lying flat, ordered 10/23/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>B. Resident #5</p> <p>Review of Resident #5's December 2024 CPO revealed the following physician's order:</p> <p>Amlodipine besylate tablet 10 milligrams (mg), give one tablet by mouth one time a day related to heart and kidney disease without heart failure, with stage one through stage four chronic kidney disease or unspecified chronic kidney disease, ordered 2/1/23.</p> <p>-The physician's order was created, confirmed and revised by the MRA.</p> <p>C. Resident #46</p> <p>Review of Resident #46's December 2024 CPO revealed the following physician's orders:</p> <p>Diet type, regular with fortified food for risk for malnutrition, ordered 9/19/24.</p> <p>-The physician's order was created by the MRA.</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>D. Resident #49</p> <p>Review of Resident #49's December 2024 CPO revealed the following physician's order:</p> <p>Speech therapy evaluate and treat as indicated, ordered 10/18/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>E. Resident #4</p> <p>Review of Resident #34's December 2024 CPO revealed the following physician's orders:</p> <p>Referral to dermatology for hair loss and itchy/painful scar, ordered 3/28/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>Diagnosis chronic sinusitis, unspecified, ordered 3/5/24.</p> <p>The physician's order was created and confirmed by the MRA.</p> <p>Potassium, total dose = 20 milliequivalents (mEq), ordered 1/5/24).</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>F. Resident #6</p> <p>Review of Resident #6's December 2024 CPO revealed the following physician's order:</p> <p>Nebulizer use, as needed every four hours, ordered 3/6/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>G. Resident #19</p> <p>Review of Resident #19's December 2024 CPO revealed the following physician's orders:</p> <p>May apply barrier cream after incontinence episode, ordered 9/13/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>Drain catheter every four hours or as needed, record characteristics and amount, ordered 6/24/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>H. Resident #262</p> <p>Review of Resident #262's December 2024 CPO revealed the following physician's orders:</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Shortness of breath while laying flat, ordered 10/23/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>May apply barrier cream after incontinence episode, ordered 9/13/23.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>Diagnosis for foley catheter: chronic kidney disease, stage 3, retention of urine, ordered 10/13/24.</p> <p>-The physician's order was created, confirmed and revised by the MRA.</p> <p>May discontinue as needed medications not used for 60 days with the exception of milk of magnesia and Tylenol, ordered 9/13/24.</p> <p>The physician's order was created and confirmed by the MRA.</p> <p>Observe closely for side effects of diuretic medication including decreased oral intake, acute confusion, agitation, delusions, aggression, tiredness, decreased sweating, rapid heart rate, low blood pressure, generalized weakness, and sunken eyes, ordered 9/13/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>I. Resident #45</p> <p>Review of Resident #45's December 2024 CPO revealed the following physician's order:</p> <p>Nebulizer: assess prior to administering nebulizer treatment document lung sounds as 1=clear 2=rales 3=congested 4=crackles 5=rhonchi 6=rubs 7=wheezing 8=diminished, ordered 1/18/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>J. Resident #47</p> <p>Review of Resident #47's December 2024 CPO revealed the following physician's order:</p> <p>May crush medication unless contraindicated, ordered 11/15/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>K. Resident #24</p> <p>Review of Resident #24's December 2024 CPO revealed the following physician's order:</p> <p>Hemodialysis every Tuesday, Thursday, and Saturday, ordered 12/10/24.</p> <p>-The physician's order was created and confirmed by the MRA.</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>II. Staff interviews</p> <p>The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 12/18/24 at 11:40 a.m. The DON said the MRA was also a certified nursing assistant (CNA) and had been permitted to enter verbal physician orders when the orders were received by electronic communication from the physician.</p> <p>The NHA said that CNAs were not permitted to create, confirm or revise physician orders because it was not in the scope of practice for a CNA.</p> <p>The DON and the NHA said they were unaware the MRA had been confirming and revising residents' physician's orders. The DON and the NHA said they would educate the MRA that she was not permitted to create, confirm or revise physician's orders.</p> <p>III. Facility follow-up</p> <p>On 12/18/24 at 4:12 p.m., the NHA provided documentation that physician's order entry education was completed with the medical records staff and nursing administration. The education clarified that only nurses could enter or confirm physician's orders for residents.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350</p> <p>Based on observations, record review and interviews, the facility to ensure for one (#5) of three residents reviewed for assistance with activities of daily living (ADL) out of 41 sample residents received the appropriate treatment and services to maintain or improve his or her abilities.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #5 was provided with the appropriate level of assistance for positioning and transfers; and, -Ensure Resident #5's care plan was updated with the appropriate level of staff assistance for transfers per therapy discharge instructions. <p>Findings include:</p> <p>I. Resident #5</p> <p>A. Resident status</p> <p>Resident #5, age 82, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke) and dementia.</p> <p>The 10/26/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. She was dependent with toileting, required substantial/maximal assistance with transfers, partial/moderate assistance with personal hygiene and bed mobility and set up assistance with eating.</p> <p>The assessment indicated Resident #5 had functional limitation of range of motion (ROM) on one side for upper and lower extremities.</p> <p>B. Observations</p> <p>On 12/16/24 at 10:00 a.m. Resident #5 was observed lying on her back in bed leaning to her right side.</p> <p>On 12/16/24 at 1:10 p.m. Resident #5 was observed lying on her back in bed leaning to her right side.</p> <p>On 12/16/24 at 3:00 p.m. Resident #5 was observed lying on her back in bed leaning to her right side.</p> <p>On 12/17/24 at 9:58 a.m. Resident #5 was observed being wheeled to her room with one staff member. The resident and the one staff member entered the room and closed the door.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/17/24 at 10:10 a.m. Resident #5's door opened and the one staff member left the room. Resident #5 was sitting in her recliner.</p> <p>-A second staff member did not enter Resident #5's room to assist with the transfer (see PT discharge summary below).</p> <p>On 12/17/24 at 10:40 a.m. Resident #5 was sitting in her recliner and leaning over the right arm of the recliner.</p> <p>C. Record review</p> <p>The activities of daily living (ADL) care plan, initiated 4/12/23 and revised 7/3/24, documented that Resident #5 was at risk for self care performance related to cognitive impairment, stroke and functional limitation in ROM related to hemiplegia (weakness on one side of the body). Interventions included assisting with ADLs, encouraging participation in ADLs, encouraging the resident to use her call light for assistance, monitoring for pain during ADLs, physical therapy (PT), occupational therapy (OT) and speech therapy screen and evaluation as necessary and one person assistance for toileting and transfers.</p> <p>-The ADL care plan failed to reveal Resident #5 required a maximum assistance of two people or a hooyer (mechanical) lift with transfers (see PT discharge summary below).</p> <p>-Additionally, the ADL care plan failed to include providing gentle ROM with ADLs and positioning interventions (see OT discharge summary below).</p> <p>The 8/29/24 OT evaluation and plan of treatment note documented Resident #5 needed skilled interventions to address positioning issues and provide education to staff to maintain gains achieved during therapy. It also documented facilitation of proper seating in a recliner or bed to reduce pressure and maintain skin integrity.</p> <p>The 9/21/24 OT discharge summary note recommendations documented nursing staff was provided education on providing gentle ROM with hygiene activities and ADLs and positioning in wheelchair.</p> <p>The 10/17/24 PT evaluation and plan of treatment note documented Resident #5 had left sided hemiplegia with impaired posture, mobility and transfer with decreased safety during transfers with need for staff training and education for safe transfers with dependent assistance to reduce fall and injury risk.</p> <p>The 11/13/24 PT discharge summary note recommendations documented two persons maximum assistance or a hooyer lift were required for Resident #5's transfers.</p> <p>-A comprehensive review of Resident #5's electronic medical record (EMR) failed to reveal documentation of nursing staff offering or providing ROM during ADLs or implementing personalized positioning interventions.</p> <p>II. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The physical therapy assistant (PTA) was interviewed on 12/18/24 at 9:41 a.m. The PTA said Resident #5 was unable to ambulate but was able to use her right side to help pivot during transfers. She said she had been seen by PT and OT for issues with positioning, transfers and bed mobility. She said the facility did not have a physical therapist on site. She said a PT came once a month or held telehealth visits. She said Resident #5 still required assistance with positioning, balance and transfers and still required maximum assistance or a hooyer lift for transfers. She said Resident #5 was discharged from PT in November 2024 and the recommendations for Resident #5's transfers and positioning were reviewed with certified nurse aides (CNA) at that time. She said the discharge recommendations were for the assistance of two maximum people or a hooyer lift for transfers and positioning to keep Resident #5 from leaning to her right side. She said Resident #5 did not tolerate the ROM stretches.</p> <p>The PTA said she did not have formal documentation on the education provided to the CNAs regarding Resident #5's transfers and positioning recommendations. She said since the education was provided, there had been a change of staff. She said she did not have access to the nursing documentation and did not know how the education and communication provided by PT and OT was communicated between members of the nursing staff. The PTA said the interventions should be included in the nursing care plan.</p> <p>CNA #3 was interviewed on 12/19/24 at 9:00 a.m. CNA #3 said Resident #5 was able to bear weight on her right leg with transfers. He said it was best to transfer the resident with a two person assist and a gait belt. He said Resident #5 was sometimes transferred with only one person assistance. He said he was unsure why she had been transferred with only one person. He said CNAs could get information from care plans and change of shift reports from other CNAs and nurses regarding residents' transfer and positioning status. He said he was not aware of any communication from PT or OT to nursing staff regarding transfers or positioning for Resident #5. CNA #3 said the nursing staff just knew the residents well enough to know what kind of assistance they needed.</p> <p>-However, observations revealed Resident #5 was transferred from her wheelchair to her recliner with the assistance of only one staff member (see observations above).</p> <p>The director of nursing (DON) and the NHA were interviewed together on 12/19/24 at 9:30 a.m. The NHA said the facility was working on getting an in-house physical therapist. She said the facility did not have a process in place currently when a resident was discharged from PT and OT on how recommendations were communicated and documented to and by nursing staff. She said it was important to have a process in place to ensure continuity of care between therapy and nursing staff so the residents could continue to maintain their optimal level of functioning.</p> <p>The NHA said Resident #5 had skin tears that had happened during transfers. She said she was not aware the resident should be transferred with the assistance of two people or a hooyer lift.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112</p> <p>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.</p> <p>Specifically, the facility failed to follow the physician's orders for Resident #4's pain medications and dressing changes.</p> <p>I. Facility policy and procedure</p> <p>The Administering Medications policy, revised April 2019, was provided by the nursing home administrator (NHA) on 12/19/24 at 9:03 a.m. It read in pertinent part,</p> <p>Medications are administered in a safe and timely manner, and as prescribed.</p> <p>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.</p> <p>II. Resident #4</p> <p>A. Resident status</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The assessment revealed the resident did not reject care.</p> <p>B. Resident interview and observations</p> <p>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.</p> <p>C. Record review</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the October 2024 CPO revealed the following physician's orders for pain management:</p> <ul style="list-style-type: none"> -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. <p>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.</p> <p>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.</p> <p>-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.</p> <p>A review of the December 2024 CPO revealed the following physician's orders for wound care:</p> <ul style="list-style-type: none"> -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. <p>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.</p> <p>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.</p> <p>-However, a review of the resident's electronic medical record revealed there was no documentation the provider was notified the site was healed.</p> <p>D. Staff interviews</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>48112</p> <p>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for two of five certified nurse aides (CNA) reviewed.</p> <p>Specifically, the facility did not complete a performance review and provide regular in-service education for CNA #2 and CNA #4.</p> <p>Findings include:</p> <p>I. Record review</p> <p>CNA #2 was hired on 8/1/19. A request for a performance review was made on 12/17/24.</p> <p>-The facility was unable to provide documentation indicating a performance review for CNA #2 was completed in the past 12 months.</p> <p>CNA #4 was hired on 5/1/23. A request for a performance review was made on 12/17/24.</p> <p>-The facility was unable to provide documentation indicating a performance review for CNA #4 was completed in the past 12 months.</p> <p>II. Staff interviews</p> <p>The director of nursing (DON) and the nursing home administrator (NHA) were interviewed on 12/18/24 at 12:25 p.m. The DON said she started work as a floor nurse at the facility in September 2024 and became the DON in October 2024. The DON said she was responsible for completing performance reviews and in-service education for CNAs.</p> <p>The NHA said performance reviews were completed based on the CNAs start date. The NHA said a performance review was not completed for CNA #2 and CNA #4.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>47350</p> <p>Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not greater than five percent.</p> <p>Specifically, the facility's medication error rate was 5.88% with two errors out of 34 opportunities for error.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the the Lispro (Humalog) insulin Kwik Pen manufacturer instruction, last updated July 2023, retrieved on 12/30/24 from https://pi.lilly.com/insulin-lispro-kwikpen-us-ifu.pdf,</p> <p>Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensure that the pen is working correctly. If you do not prime before each injection you may get too much or too little insulin.</p> <p>To prime your pen, turn the dose knob to select two units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with the needle until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle.</p> <p>II. Facility policy and procedure</p> <p>The Administering Medication policy and procedure, reviewed April 2019, was provided by the nursing home administrator (NHA) on 12/19/24 at 9:03 a.m. It read in pertinent part,</p> <p>Medications are administered in accordance with prescriber orders, including any required time frame.</p> <p>The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p> <p>III. Observations</p> <p>On 12/18/24 at 11:20 a.m. registered nurse (RN) #1 checked Resident #13's insulin order for Lispro insulin five units to be administered before lunch per sliding scale for a blood glucose level of 262.</p> <p>RN #1 placed a new disposable needle onto the insulin pen and dialed one unit of insulin into the insulin pen. She pushed the one unit of insulin through the pen.</p> <p>(continued on next page)</p>		

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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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN #1 then dialed five units of insulin into the pen and administered the insulin into the back of Resident#13's right arm. After administering the insulin, RN #1 removed the needle from the insulin pen and placed it in the sharps container.</p> <p>-RN #1 failed to prime the insulin pen appropriately with two units of insulin prior to administering Resident #13's five units of insulin (see professional reference above).</p> <p>On 12/19/24 at 8:00 a.m. certified nurse aide with medication authority (CNA-Med) #2 checked Resident #44's order for aripiprazole five milligrams (mg) to be administered every morning. She obtained Resident #44's aripiprazole medication card which contained unscored ten mg tablets. She went to the medication room and was unable to find a card for Resident #44's aripiprazole five mg tablets. She notified the nurse at the desk to order the aripiprazole five mg tablets for Resident #44. She also notified the nurse at the desk to notify the provider the medication was held because the correct dosage was unavailable for administration.</p> <p>-Resident #44 did not receive the medication on 12/19/24 due to the correct dose of the medication being unavailable.</p> <p>IV. Staff interviews</p> <p>RN #1 was interviewed on 12/18/24 at 11:30 a.m. She said her practice for priming any insulin pen was to prime it with one unit of insulin because this was what she was taught. She said she did not know the manufacturer's recommendations for priming the Lispro insulin pen. She said it was important to prime the insulin pen correctly in order to administer the correct dose of insulin.</p> <p>The NHA was interviewed on 12/18/24 at 11:35 a.m. She said she was unsure of how much insulin was needed to prime insulin pens. She said she would get the correct priming information from the pharmacy regarding the pens to ensure residents received the correct dose of insulin.</p> <p>The NHA was interviewed a second time on 12/18/24 at 12:30 p.m. The NHA said the correct dose of insulin to prime the Lispro (Humalog) insulin pen was two units. She said the facility was providing education to all nurses on the correct way to prime insulin pens and to follow manufacturer's recommendations on priming insulin pens.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350</p> <p>Based on observations, record review and interviews, the facility failed to ensure the residents were free from significant medication errors for one (#13) of seven residents reviewed for medication errors out of 41 sample residents.</p> <p>Specifically, the facility failed to ensure that Resident #13 was administered the correct dose of insulin by properly priming the insulin pen before insulin administration.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the the Lispro (Humalog) insulin Kwik Pen manufacturer instruction, updated July 2023, retrieved on 12/20/24 from https://pi.lilly.com/insulin-lispro-kwikpen-us-ifu.pdf,</p> <p>Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensure that the pen is working correctly. If you do not prime before each injection you may get too much or too little insulin.</p> <p>To prime your pen, turn the dose knob to select two units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with the needle until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle.</p> <p>II. Resident #13</p> <p>A. Resident status</p> <p>Resident #13, age 85, was admitted on [DATE] and readmitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus (DM) and hypertension.</p> <p>The 9/9/24 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. He required supervision with eating, toileting, personal hygiene, transfers and was independent with bed mobility.</p> <p>B. Observations</p> <p>On 12/18/24 at 11:20 a.m. registered nurse (RN) #1 checked Resident #13's insulin order for Lispro insulin five units to be administered before lunch per sliding scale for a blood glucose level of 262.</p> <p>RN #1 placed a new disposable needle onto the insulin pen and dialed one unit of insulin into the insulin pen. She pushed the one unit of insulin through the pen.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN #1 then dialed five units of insulin into the pen and administered the insulin into the back of Resident#13's right arm. After administering the insulin, RN #1 removed the needle from the insulin pen and placed it in the sharps container.</p> <p>-RN #1 failed to prime the insulin pen appropriately with two units of insulin prior to administering Resident #13's five units of insulin (see professional reference above).</p> <p>C. Record review</p> <p>Review of Resident #13's December 2024 CPO revealed a physician's order for Humalog (Lispro) insulin 100 units/milliliter (ml) to inject five units per sliding scale for a blood glucose of 251-999 subcutaneously before meals for diabetes mellitus, ordered 9/3/24.</p> <p>III. Staff interviews</p> <p>RN #1 was interviewed on 12/18/24 at 11:30 a.m. She said her practice for priming any insulin pen was to prime it with one unit of insulin because this was what she was taught. She said she did not know the manufacturer's recommendations for priming the Lispro insulin pen. She said it was important to prime the insulin pen correctly in order to administer the correct dose of insulin.</p> <p>The nursing home administrator (NHA) was interviewed on 12/18/24 at 11:35 a.m. She said she was unsure of how much insulin was needed to prime insulin pens. She said she would get the correct priming information from the pharmacy regarding the pens to ensure residents received the correct dose of insulin.</p> <p>The NHA was interviewed a second time on 12/18/24 at 12:30 p.m. The NHA said the correct dose of insulin to prime the Lispro (Humalog) insulin pen was two units. She said the facility was providing education to all nurses on the correct way to prime insulin pens and to follow manufacturer's recommendations on priming insulin pens.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112</p> <p>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.</p> <p>Specifically, the facility failed to offer food choices according to Resident #12's preferences.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>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.</p> <p>Between meals and bedtime snacks are offered. These snacks are of a nutritious quality.</p> <p>II. Resident #12</p> <p>A. Resident status</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>B. Resident interview and observation</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>C. Record review</p> <p>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.</p> <p>The 8/19/24 nutritional risk assessment revealed the residents liked sweets, sweet tea, chips, fruit loops, peanut butter, grapes, corn, jello and pork.</p> <p>D. Observations</p> <p>On 12/18/24 at 11:10 a.m. during a kitchen tour, grapes were not observed in the kitchen.</p> <p>E. Staff interviews</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48114</p> <p>Based on observations, record review and interviews, the facility failed to prepare, distribute and serve food in a sanitary manner in the main kitchen.</p> <p>Specifically, the facility failed to ensure hand hygiene was conducted appropriately in the main kitchen.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 12/24/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.</p> <p>If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.</p> <p>II. Facility policy and procedure</p> <p>The Handwashing and Hand Hygiene policy and procedure, revised August 2019, was provided by the nursing home administrator (NHA) on 12/19/24 at 2:07 p.m. It read in pertinent part, All personnel shall be trained and regularly in-services on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.</p> <p>All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>The use of gloves does not replace hand washing/hand hygiene. Integration of gloves use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.</p> <p>When applying and removing gloves, perform hand hygiene before applying non-sterile gloves.</p> <p>II. Observation</p> <p>During a continuous observation during the lunch meal on 12/18/24, beginning at 11:00 a.m. and ending at 2:00 p.m., the following was observed:</p> <p>Cook (CK) #1 reached into the bucket of sanitizer and got a towel. He began sanitizing his work area. He put the towel back into the sanitizer bucket and picked up some dirty dishes and took them to the dish area. He took his gloves off and put a new pair of gloves on without washing his hands.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>CK #1 had gloves on, grabbed the hot pads and pulled the meatloaf out of the oven and sat it on the counter.</p> <p>Without removing his gloves, he got a knife from the drawer and began slicing the meatloaf. When he was done slicing up the meatloaf he took the pan and placed it on the steam table. He took his gloves off and put new gloves on without washing his hands.</p> <p>With the same gloves hands CK #1 went into the back room and grabbed a bag of instant mashed potatoes. He grabbed the scissors and opened the bag and poured the bag of instant mashed potatoes into the pan. He grabbed a picture of water and filled it up with hot water. He poured the hot water into the pan of instant mashed potatoes and began mixing the mashed potatoes. When he was done mixing the potatoes he placed the pan on the steam table. He then took his gloves off and then put new gloves on without washing his hands.</p> <p>With his gloved hands CK #1 grabbed a spatula from the drawer and placed four pieces of meatloaf in the blender. He got a measuring cup, went to the sink and filled it with water. He then poured the water into the blender. When he was done pureeing the meatloaf he took it over to the steam table. He grabbed a small pan and scooped the pureed meatloaf into the pan. When he was done he took the blender back to the dish room He took his gloves off and put new gloves on without washing his hands.</p> <p>With gloved hands CK #1 went to the fridge and got the pie that was for dessert. He grabbed a knife from the drawer and began slicing the pie with the same gloved hands. He placed the sliced pie on a plate using his gloved hands. He picked up four trays and laid them on the counter. He then picked up the meal tickets and placed them on the trays.</p> <p>With gloved hands CK #1 before lunch service began he reached into his pocket of his pants and pulled out a pen.</p> <p>The regional director of dietary services consultant (RDDSC) told CK #1 that he needed to change his gloves. CK #1 took his gloves off and then put new gloves on without washing his hands.</p> <p>With gloved hands CK #1 began plating the lunch trays for the dining room. When he ran out of the serving trays he grabbed more serving trays from the counter next to the steam table. He then took four trays and lined them up on the counter and grabbed more meal tickets and placed them on the trays. He then began plating the meal on the plate.</p> <p>With gloved hands CK #1 took a meal ticket and walked out of the kitchen to ask a resident what they were ordering. When CK #1 returned to the kitchen he took his gloves off and then put new gloves on without washing his hands.</p> <p>With gloved hands CK #1 grabbed a frying pan and placed it on the stove and then he went to the fridge and grabbed two pasteurized eggs. He cracked one egg into the pan and cooked the egg. He then grabbed a clean plate and placed the fried egg on the plate. He then set the plate down and cracked another egg into the pan. When the second egg was done he placed it on the plate. He then took his gloves off and then put new gloves on without washing his hands.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>With gloved hands CK #1 went to the freezer and took out chicken tenders. He then placed the chicken into the fryer and wrapped up the bag and placed it back into the freezer. When the chicken tenders were done he placed them on a plate. He then grabbed a tray and placed the plate on the tray and then walked out of the kitchen. He told the staff that he was going to deliver the tray to the resident. He walked out of the kitchen. When he came back he took off his gloves and put new gloves on without washing his hands.</p> <p>III. Staff interviews</p> <p>The dietary manager (DM) and the RDDSC were interviewed together on 12/18/24 at 3:14 p.m. The DM said gloves should be changed between tasks. The DM said the staff should wash their hands before putting gloves on and after removing gloves. The DM said the staff should change their gloves between tasks. She said she was not sure why CK #1 was not washing his hands after disposing of their gloves and putting on a clean pair. She said she was going to provide education to the staff on hand hygiene.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47350</p> <p>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.</p> <p>Specifically, the facility failed to ensure glucometers were cleaned in a sanitary manner.</p> <p>I. Professional reference</p> <p>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,</p> <p>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.</p> <p>II. Facility policy and procedure</p> <p>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,</p> <p>Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use.</p> <p>III. Manufacturer's recommendations</p> <p>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,</p> <p>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.</p> <p>The meter should be cleaned and disinfected after use on each patient.</p> <p>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).</p> <p>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.</p> <p><i>(continued on next page)</i></p>		

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
NAME OF PROVIDER OR SUPPLIER River Valley Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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,</p> <p>Bactericidal, Tuberculocidal, Virucidal and Fungicidal. Overall contact time is two minutes.</p> <p>IV. Observations</p> <p>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.</p> <p>-RN #1 did not use two wipes to clean and disinfect the meter (see manufacturer's recommendations above).</p> <p>-RN #1 did not leave the glucometer wet for the two minute disinfection time (see manufacturer's recommendations above).</p> <p>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.</p> <p>-RN #1 did not use two wipes to clean and disinfect the meter (see manufacturer's recommendations above).</p> <p>-RN #1 did not leave the glucometer wet for the two minute disinfection time (see manufacturer's recommendations above).</p> <p>V. Record review</p> <p>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.</p> <p>VI. Staff interviews</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p>		