STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviva at Fitzsimons	13525 E 23rd Ave Aurora, CO 80045

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 - Few

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 50219

Based on observations and interviews, the facility failed to ensure care for residents was provided timely and in a manner that maintained or enhanced the residents' dignity for two residents (#32 and #3) out of four residents reviewed for dignity of 26 sample residents.

Specifically, the facility failed to provide Resident #32 and Resident #3 with a dignified existence by ensuring call lights were consistently answered in a timely manner.

Findings include:

I. Resident #32

A. Resident status

Resident #32, age less than 65, was admitted on [DATE]. According to the October 2024 computerized physicians order (CPO), diagnoses included chronic respiratory failure and amyotrophic lateral sclerosis (a neurodegenerative disease that affects the nerve cells that control muscles).

The 7/11/24 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 resident was dependant on staff for all activities of daily living (ADL).

B. Resident and resident representative interview

Resident #32 and his representative were interviewed together on 10/3/24 at 4:15 p.m. Resident #32 said he had issues with wait times for call light responses at night when he needed help. Resident #32's representative said the resident's call lights were left on for 15 to 20 minutes at a time with no response. Resident #32's representative said the CNAs came into the resident's room and turned off his call light without providing him with assistance, so now they had no way of documenting how long Resident #32 had been waiting. Resident #32 said the issue was inhumane.

C. Record review

(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: 065430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Aviva at Fitzsimons		STREET ADDRESS, CITY, STATE, ZIP CODE 13525 E 23rd Ave Aurora, CO 80045	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADL care plan, dated 1/8/24, revealed Resident #32 had deficits in his ADL performance due increased weakness. Pertinent interventions included encouraging Resident #32 to use his call light to call for assistance. The fall care plan, dated 1/8/24, revealed Resident #32 was at risk for falls due to an inability to self-reposition. Pertinent interventions included ensuring Resident #32's call light was within reach and encouraging the resident to use it for assistance as needed as the resident needed prompt response to all requests for assistance. The myopathy care plan, dated 1/2/24, revealed Resident #32 had an alteration in his musculoskeletal status due to disease progression. Pertinent interventions included anticipating and meeting needs, ensuring Resident #32's call light was within reach and responding promptly to all requests for assistance. On 7/15/24 Resident #32's representative filed a grievance report which revealed neither the resident nor his representative had seen any improvements in call light times over 10 minutes. The resolution revealed staff education was provided on 7/16/24 regarding answering call lights timely, meeting the needs of residents, and waiting for a response before leaving the room. -However, Resident #32 was still experiencing long call wait times (see interview above). On 8/8/24 Resident #32's representative filed another grievance report that revealed on the date of the report the resident had waited 25 minutes for an respiratory therapist (RT). Resident #32 had asked a CNA twice for an RT but did not receive any response. The resolution, dated 8/13/24, revealed a training and inservice was conducted with the nursing staff which enforced answering call lights and following up on them as soon as possible. -However, Resident #32 was still experiencing long call wait times (see interview above). Call light records for Resident #32 from 9/3/24 to 10/4/24 were reviewed and revealed the following: -Activated on 9/3/24 at 9:46 p.m. for 33 minutes; -Activated on 9/4/24 at 5:56 a.m. for 24 minutes; -Activated on 9/5/24 at 4:24 a.m. for 24 minutes; -Activated on 9/5/24 at 8:47 p.m. for 42 minutes; -Activated on 9/7/24 at 7:07 p.m. for 21 minutes; -Activated on 9/7/24 at 7:51 p.m. for 21 minutes; -Activated on 9/10/24 at 4:48 a.m. for 25 minutes; -Activated on 9/10/24 at 9:37 p.m. for 21 minutes; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Activated on 9/11/24 at 5:23 a.m. for 24 minutes; -Activated on 9/12/24 at 7:28 p.m. for 24 minutes; -Activated on 9/12/24 at 8:48 p.m. for 29 minutes; -Activated on 9/12/24 at 9:46 p.m. for 25 minutes; -Activated on 9/13/24 at 5:53 a.m. for 33 minutes; -Activated on 9/15/24 at 4:53 a.m. for 38 minutes; -Activated on 9/16/24 at 5:15 a.m. for 35 minutes; -Activated on 9/18/24 at 3:17 a.m. for 23 minutes; -Activated on 9/19/24 at 3:48 a.m. for 23 minutes; -Activated on 9/22/24 at 6:09 p.m. for 29 minutes; -Activated on 9/23/24 at 3:57 a.m. for 27 minutes; -Activated on 9/24/24 at 5:49 a.m. for 26 minutes; -Activated on 9/25/24 at 3:53 a.m. for 21 minutes; -Activated on 9/26/24 at 3:21 a.m. for 30 minutes; -Activated on 9/26/24 at 4:47 a.m. for 42 minutes; -Activated on 9/26/24 at 11:19 p.m. for 24 minutes; -Activated on 9/27/24 at 4:32 a.m. for 41 minutes; -Activated on 9/30/24 at 4:53 a.m. for 50 minutes; -Activated on 10/1/24 at 1:25 a.m. for 30 minutes; -Activated on 10/1/24 at 3:39 a.m. for 27 minutes; -Activated on 10/1/24 at 11:20 p.m. for 25 minutes; -Activated on 10/2/24 at 4:42 a.m. for 22 minutes; -Activated on 10/2/24 at 7:14 a.m. for 20 minutes; -Activated on 10/2/24 at 8:49 p.m. for 32 minutes; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Activated on 10/3/24 at 12:14 a.m. for 21 minutes; -Activated on 10/3/24 at 2:15 a.m. for 22 minutes; and, -Activated on 10/3/24 at 4:30 a.m. for 43 minutes. II. Resident #3 A. Resident Status Resident #3, age 83, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), hemiplegia (weakness in one side of the body) and hemiparesis (paralysis in one side of the body). The 7/5/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was dependant on staff for most ADLs. B. Resident interview Resident #3 was interviewed on 10/2/24 at 10:16 a.m. Resident #3 said the nursing staff had recently changed from 12 hour shifts to eight hour shifts and it seemed like they were not answering call lights as quickly since the change. Resident #3 said it took the nursing staff 15 to 20 minutes at a minimum before her call light was answered. Resident #3 said she sometimes had to put her call light on two or three times before someone responded. Resident #3 said some of the certified nurses aides (CNA) were quicker to respond to the call lights than others and call light response times were longer in the late afternoon. Resident #3 was interviewed a second time on 10/7/24 at 3:03 p.m. Resident #3 said she used her call light whenever she needed ice or water. Resident #3 said she tried not to use her call light excessively, as she realized the CNAs were busy. Resident #3 said since the change in scheduling she sometimes had to wait much longer for her call light to be answered. Resident #3 said waiting 15 to 20 minutes for a response may not have seemed like much, but since she was debilitated made her wonder if they were ever going to come and help her. C. Record review The ADL care plan, revised 10/27/23, revealed Resident #3 had deficits in her ADL performance due hemiplegia and decline due to disease process. Pertinent interventions included encouraging Resident #3 to use her call light to call for assistance. The fall care plan, dated 7/26/22, revealed Resident #3 was at risk for falls due to lack of mobility. Pertinent interventions included ensuring Resident #3's call light was within reach and encouraging the resident to use it for assistance as needed as the resident needed prompt response to all requests for assistance. The oxygen therapy care plan, revised 1/28/23, revealed Resident #3 received oxygen therapy for her COPD. Pertinent interventions included having an agreed-on method for Resident #3 to call for assistance and having a staff member stay with her during episodes of respiratory distress. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Call light records for Resident #3 from 9/3/24 to 10/4/24 were reviewed and revealed the following: -Activated on 9/12/24 at 8:18 p.m. for 41 minutes; -Activated on 9/14/24 at 7:32 p.m. for 21 minutes; -Activated on 9/19/24 at 6:50 p.m. for 60 minutes; -Activated on 9/24/24 at 8:03 p.m. for 42 minutes; -Activated on 9/28/24 at 8:17 p.m. for 61 minutes; and, -Activated on 9/30/24 at 8:35 p.m. for 31 minutes. III. Staff interviews CNA #1 was interviewed on 10/7/24 at 3:29 p.m. CNA #1 said she answered the call lights as soon as she saw them. She said the CNAs had phones that beeped whenever the call lights were activated. CNA #1 said when she saw multiple call lights were activated, she went to whichever one she saw first. CNA #1 said the residents used the call lights when they needed to be changed, were ready for their shower, or needed to use the urinal. CNA #1 said Resident #32 used his call light whenever he needed a RT. CNA #1 said the facility's goal was to answer call lights within five to ten minutes of being activated. CNA #1 said the call lights were sometimes on for longer than that goal because the CNAs were already giving showers, helping the nurses change dressings, or helping reposition residents. CNA #1 said Resident #32 sometimes complained about the length of time his call light was activated, to which CNA #1 said she just apologized. CNA #1 said she knew of one instance where it took a longer time to answer Resident #32's call light in which she was helping transfer another resident. CNA #6 was interviewed on 10/8/24 at 9:33 a.m. CNA #6 said she usually had ten to eleven residents depending on the facility census that day. CNA #6 said the facility's call light system did not make a sound but instead they had telephones that rang when the lights were activated. CNA #6 said when there were multiple call lights going off, she checked the phone to see how many minutes the lights had been going off. CNA #6 said Resident #32 used his call light more so she tried to get to his room as fast as possible. CNA #6 said she tried to answer the call lights as quickly as possible but the facility's goal was five to six minutes. CNA #6 said certain residents called over and over for the same things. CNA #6 said longer call light times depended on how the facility was staffed, as when they had less staff things took more time. CNA #6 said most of the residents required the assistance of two staff members, so sometimes when the CNAs were showering residents everyone was occupied so call lights were activated for longer. CNA #6 said the facility also brought in a lot of agency staff which made things more difficult as the agency staff did not have the same routine or know the residents as well. CNA #6 said Resident #3 used her call light to ask for ice or an RT. CNA #6 said Resident #3 was alert and oriented and knew to use her call light whenever she needed help. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #5 was interviewed on 10/8/24 at 9:44 a.m. LPN #5 said the goal for answering call lights was within five minutes. LPN #5 said they had a pager or phone system to let the nursing staff know when the call lights were activated. LPN #5 said the phone system cycled through with whether or not it was working. LPN #5 said she was not sure if the pagers were working or not, but the CNAs on shift that day had her nurse phone. LPN #5 said if the nurse phone started beeping that meant the call light had been activated for a while. LPN #5 said the pager system worked by having the CNAs receive the page first, then the nurses, then the unit manager. LPN #5 said since there was not presently a unit manager the system ended with the nurse on shift. She said the facility was trying to hire a unit manager. LPN #5 said the administration would call and ask why the call lights were still activated if they had been on for an extended period. LPN #5 said longer call light times could be caused by the RT needing help with a resident or if the CNAs were already in a room. LPN #5 said there were a lot of agency staff who did not answer call lights or keep up with call light response times. LPN #5 said LPN #3 was working on servicing the phones the week prior. LPN #5 said the CNAs knew to look up and down the hallway to check and see which call lights were going off. CNA #2 was interviewed on 10/8/24 at 9:49 a.m. CNA #2 said the unit used to have two phones for the CNAs but they were gone. CNA #2 said someone took them to get them fixed. LPN #3 was interviewed on 10/8/24 at 10:15 a.m. LPN #3 said he had taken over some of the unit manager responsibilities until the facility could hire one. LPN #3 said the call lights notified the nursing staff in a few ways. LPN #3 said once the call light was activated, it pushed alerts out to the notification system. LPN #3 said these notifications were sent out to pagers, which they had been struggling to keep functioning and cell phones. LPN #3 said ideally each CNA would have a pager. LPN #3 said he had gathered all the pagers the week prior to send them out for servicing. LPN #3 said there was a monitor in the administration office that showed how long the call lights had been activated and the managers got alerts once the call light had been activated over three minutes. LPN #3 said the goal for answering call lights was within three minutes. LPN #3 said call light times were typically longer in the hospital back-up unit because the CNAs had to work in pairs while providing care. LPN #3 said the facility had received grievances about call light times periodically. LPN #3 said the response for these grievances involved creating a plan of action that usually involved reeducating the staff before going back to the resident that submitted the grievance and ensuring they were satisfied with the outcome. LPN #3 said there had not been any issues brought to his attention regarding agency staff differing in call light response compared to the facility staff. The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 10/8/24 at 11:56 a.m. The DON said the facility's call light system was electronic and notifications were sent to cell phones. The DON said the notifications immediately went to the CNAs, then were sent to the nurses after two to five minutes, then to the unit manager after ten minutes, and to the DON after 20 minutes of being activated. The DON said the administrative team had directed the nursing staff to go into the room once the call light was activated, but leave the call light on if the staff member could not meet the need of the resident and needed to retrieve another staff member such as an RT or nurse. The DON said this may skew the call light times. The DON said the nursing staff also forgot to turn off the call lights after addressing the resident's needs. The DON said call lights could be longer if the RT was having an emergency. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she had called in during the night to see why call lights were not being answered timely. The DON said she encouraged residents to activate their call light again if they felt they had not had their needs addressed. The DON said she had also educated the staff on giving residents time to respond and communicate their needs. The DON said sometimes the staff asked rapid-fire questions and did not give Resident #32 the time he needed to respond. The DON said the facility had moved away from using pagers and transferred to cell phones. The NHA said she had received complaints about not having chargers for the cellphones. The NHA said she addressed this so there would be chargers that could not be unplugged and moved so they would not go missing. The DON said the facility had a lot of staff that were just floating around and not doing anything so they had to address those concerns.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47064 Based on record review and interviews, the facility failed to complete a performance review ofevery nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for four of five certified nurse aides (CNA). Specifically, the facility failed to complete annual performance reviews for CNA #2, CNA #3, CNA #4 and CNA #5 in order to determine potential training needs. Findings include: I. Facility policy and procedure The In-Service Training, Nurse Aide policy and procedure, revised August 2022, was received from the infection preventionist (IP) on 10/7/24 at 1:02 p.m. It revealed in pertinent part, All nurse aide personnel participate in regular in-service education. The facility completes a performance review of nurse aides at least every 12 months. In-service training is based on the outcome of the annual performance reviews. Supervised practical training means training in a setting in which instruction and oversight are provided by a person who has relevant education and/or experience specific to the subject of the training being provided. Training curriculum includes learning objectives, performance standards and evaluation criteria. Nurse aides are evaluated based on individual performance when appropriate. Competency may also be demonstrated through a written exam or by consistently applying interventions necessary to meet the needs of the residents as identified in the facility assessment. II. Record review Annual performance reviews were requested on 10/3/24 at 10:40 a.m. for CNA #2 (hired on 12/30/22), CNA #3 (hired on 6/6/23), CNA #4 (hired on 1/26/23) and CNA #5 (hired on 4/13/23). -The facility was unable to provide annual performance evaluations or regular in-service education based on the outcome of the reviews for CNA #2, CNA #3, CNA #4 or CNA #5. III. Staff interviews The nursing home administrator (NHA) was interviewed on 10/7/24 at 2:47 p.m. The NHA said annual performance evaluations had not been completed for CNAs. The NHA said the facility was implementing a process, going forward, where human resources would print out a list of CNAs/staff who required annual performance evaluations for each manager to complete. The NHA said each manager would then be responsible for getting them completed and she would review the evaluations prior to them being given to the staff for finalization.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47064

Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%).

Specifically, the facility had a medication error rate of 6.06%, or two errors out of 33 opportunities for error.

Findings include

I. Professional reference

According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights:

1. The right medication

2. The right dose

3. The right patient

4. The right route

5. The right time

6. The right documentation

7. The right indication.

II. Facility policy and procedure

The Medication Administration policy and procedure, dated 2/29/24, was received from the infection preventionist (IP) on 10/7/24 at 1:02 p.m. It revealed in pertinent part, Resident medications are administered in an accurate, safe, timely and sanitary manner.

Physician orders are administered in accordance with written orders of the attending physician or physician extender. If a dose is inconsistent with the resident's age and condition or medication order is inconsistent with the resident's current diagnosis or condition, contact the physician for clarification prior to the administration of the medication. Document the interaction with the physician in the nursing progress notes and elsewhere in the medical record, as appropriate.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify the medication label against the medication administered record (MAR) for accuracy of drug frequency, duration, strength and route. Follow safe preparation practices as follows: Be sure to check the bottle label against the physician's orders. Medication is to be given in compliance with the physician orders and or manufactures recommendations. III. Observations and interviews On 10/3/24 at 5:20 p.m. licensed practical nurse (LPN) #4 was administering medications to Resident #2. LPN #4 dispensed one tablet of Lactaid 9000 units. Resident #2's MAR indicated the resident had a physician's order for Lactaid oral tablet 3000 units via nasogastric tube (NGT) two times a day for abdominal bloating. -LPN #4 dispensed one tablet of Lactaid 9000 units. This was 6000 units more than the physician's order indicated the resident was to receive. When LPN #4 was asked to review the physician's order for Lactaid. After reviewing the order, she said she could cut the tablet in half. LPN #4 proceeded to cut the tablet in half with a pill cutter and placed a half tablet into the medication cup. -The half tablet of Lactaid 9000 units was still 1500 units more than the physician's order indicated the resident was to receive. LPN #4 was asked a second time to review Resident #2's Lactaid order. LPN #4 said she should have cut the tablet into three parts so it would equal the 3000 units of Lactaid indicated by the physician's order. LPN #4 removed the half tablet from the medication cup and disposed of the tablet. At 5:44 p.m. LPN #4 said she needed to check central supply to see if the facility carried the 3000 unit dose of Lactaid the physician ordered for Resident #2. LPN #4 checked the central supply medications and said the only Lactaid in stock was the 9000 units dose. She added Lactaid 3000 units to the order supply list in central supply. -LPN #4 did not administer Resident #2's Lactaid because she did not have the correct dose. LPN #4 said if a medication tablet did not have a score line (mark or indentation down the middle of a medication tablet that allows for accurate cutting of the medication) by the manufacturer it should not be cut. LPN #4 said she should not have attempted to administer the Lactaid tablet she cut with a pill cutter because it did not follow the dose the physician had ordered for Resident #2. LPN #4 said cutting a tablet in half that did not have a score line was not safe because staff could not ensure the medication concentration would equal the dose ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 8:20 a.m. LPN #2 was administering medications to Resident #11. Resident #11's MAR revealed the resident had a physician's order for Flonase suspension 50 microgram/actuation (mcg/act) two inhalations in both nostrils every 12 hours for allergy, runny nose and sinusitis. LPN #2 said he was unable to find the medication so he reordered it from the pharmacy. LPN #2 said he documented the medication was on order with the pharmacy in the MAR. -LPN #2 did not administer the medication to Resident #11 as ordered because the medication was not available. IV. Additional staff interviews LPN #3, who was also the unit manager, was interviewed on 10/7/24 at 10:18 a.m. LPN #3 said nurses were not supposed to cut medication tablets in half unless they contained a score line created in the medication by the manufacturer. LPN #3 said cutting a tablet without a score line in half could lead to the wrong dose of the medication being administered to a resident. She said cutting medications in half was the responsibility of the pharmacist. LPN #3 said if a medication was not available it should be ordered and the physician should be contacted to be notified of the missing dose. She said nurses should get an order from the physician to hold a medication until it was available or see if the physician wanted to change the medication to a different dose the facility may have on hand. The director of nursing (DON) was interviewed on 10/7/24 at 10:32 a.m. The DON said nurses were not to cut medication tablets in half unless the medication was scored. The DON said cutting an unscored tablet could lead to the resident getting too much or too little of a medication. The DON said if a medication was not available at the time of an ordered administration, the pharmacy should be contacted to reorder the medication. She said the physician should be contacted to inform them of the missing dose and get an order on how to proceed, whether it be to hold the medication until it was available or change the medication to a different dose on hand.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50219 Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen. Specifically, the facility failed to ensure ready-to-eat foods were handled in a sanitary manner to prevent cross contamination. Findings include: I. Failed to ensure ready-to-eat foods were handled in a sanitary manner A. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 10/8/24 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. 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. B. Facility policy and procedure The Food Wholesomeness: Procurement, Storage, Preparation and Service Sanitary Conditions Policy, revised January 2024, was received from the nursing home administrator (NHA) on 10/7/24 at 2:30 p.m. It revealed in pertinent part, Food is handled properly with frequent handwashing and proper sanitation guidelines per local, state and federal guidelines and codes. C. Observations During a continuous observation of the dinner meal service on 10/3/24, beginning at 4:40 p.m. and ending at 5:42 p.m. the following was observed: At 4:50 p.m. cook (CK) #1 was wearing a pair of gloves and handling meal tickets, plate warmers, a door handle and serving utensils. Using the same gloved hands, CK #1 sliced a chicken breast on the griddle and used his gloved hand to stabilize the chicken while he scooped it up with a spatula before setting it on a plate. CK #1 then took out a bag of bread, opened the plastic bag, and grabbed two slices of bread with the same gloved hands before setting them on the griddle. Using the same gloved hands, CK #1 grabbed a handful of french fries out of the fryer basket and set them on a plate. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:55 p.m. CK #2 began preparing a southwest salad. Using gloved hands, CK #2 opened the cold storage doors and took out a container of lettuce. Using the same gloved hands, CK #2 removed the lettuce lid and grabbed handfuls of lettuce to put into a bowl. CK #2 repeated this process with containers of chopped red onion and tortilla strips. At 5:00 p.m. CK #1 washed his hands and donned (put on) a new set of gloves. CK #1 handled several serving utensils before grabbing a handful of fries using his gloved hands and setting them on a plate. After this, CK #1 used a spatula to scoop up a cooked chicken breast and place it on a plate. CK #1 then used the same gloved hands to adjust the chicken breast on the plate before serving it. At 5:07 p.m. CK #2 was wearing a pair of gloves. CK #2 opened the cold storage doors and took out a container of egg salad. CK #2 set the egg salad container on the table and with the same gloved hands that had touched the lettuce she had previously set on a plate At 5:10 p.m. CK #2 was preparing a to-go order salad. CK #2 took out a cardboard to-go container and using the same gloves retrieved the container of lettuce from the cold storage and took out handfuls of lettuce using the same gloved hands. At 5:25 p.m. CK #2 was handling meal tickets and serving utensils before returning to the to-go order salad. CK #2 sliced an avocado and used her same gloved hands to peel the skin off the avocado before placing the avocado slices into the to-go salad container. At 5:29 p.m. CK #1 was handling meal tickets and serving utensils on the service line with gloved hands. Using the same gloved hands, CK #1 picked up the plastic bread bag and used his gloved hand to push the slices of bread down before closing the bag and putting it away. D. Staff interview The dietary manager (DM) was interviewed on 10/7/24 at 12:19 p.m. The DM said the dietary staff typically did not handle much ready-to-eat food but that ready-to-eat food should be handled with gloves and clean utensils. The DM said gloves should be changed any time a staff member started a new task. The DM said gloves needed to be removed when handling meal tickets and new gloves donned afterward. The DM said one of the cooks was new to the role, so she was still trying to instill good hand hygiene habits in him.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to implement their policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption on one of two units. Specifically the facility failed to ensure safe and appropriate storage of food items in personal resident refrigerators. Findings include: A. Professional reference The Colorado Retail Food Establishment Regulations, ([DATE]), were retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Refrigerated, ready-to-eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises or discarded The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. B. Facility policy and procedure The Foods Brought by Family/Visitors policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 10:28 a.m. It revealed in pertinent part, Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. The nursing staff will discard perishable foods on or before the use by date. C. Resident interview Resident #3 was interviewed on [DATE] at 10:16 a.m. Resident #3 said her refrigerator had not been checked by a member of the dietary staff in months. Resident #3 was interviewed again on [DATE] at 9:58 a.m. Resident #3 said her daughter had come two days prior, defrosted her refrigerator and threw away all of the food items that had expired. -However, multiple items remained in the refrigerator that were expired. C. Observations and record review On [DATE] at 10:16 a.m. the following items were found in Resident #3's refrigerator: (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An open bag of croutons, with an expiration date of [DATE]; -A bottle of Caesar salad dressing, with an expiration date of [DATE]; -A bottle of barbeque sauce, with an expiration date of [DATE]; -Another bottle of barbeque sauce, with an expiration date of [DATE]; -A slice of zucchini bread wrapped in plastic wrap that had no date; -Two containers cocktail sauce, with an expiration date of [DATE]; -A bag of sliced carrots, that had no date or label on it; and, -Two opened containers of chocolate pudding, with no date. -There were 10 to 15 small gnats or fruit flies that were dead at the inside of the refrigerator at the bottom. The paper on the side of the refrigerator was labeled [DATE] with columns for refrigerator and freezer temperatures. The temperatures for [DATE] and [DATE] had not been filled out. The following items were found in Resident #3's refrigerator [DATE] at 9:58 am: -The same open bag of croutons, with an expiration date of [DATE]; -The same bottle of barbeque sauce, with an expiration date of [DATE]; and, -An unlabeled and undated tupperware container of asparagus. The paper on the side of the refrigerator was labeled [DATE] with columns for fridge and freezer temperatures. The temperatures for [DATE] through [DATE] had not been filled out. D. Staff interview The dietary manager (DM) was interviewed on [DATE] at 12:19 p.m. The DM said the dietary staff had temperature logs for Resident #3's personal refrigerator. The DM said the dietary staff went through Resident #3's refrigerator to throw expired food items away and to ensure any food brought in by the resident's family was appropriately labeled and dated. The DM was interviewed again on [DATE] at 12:40 p.m. She said, while reviewing the contents of Resident #3's refrigerator, the refrigerator had a temperature log for [DATE] that no one had filled out. The DM said the expired croutons and the barbeque sauce needed to be thrown away. She asked Resident #3 if she could throw them away. The DM said there was a cook that was previously employed at the facility that was really consistent with checking through Resident #3's refrigerator. The DM said she had told the dietary staff members to ensure they were checking Resident #3's refrigerator and fill out the respective temperature log whenever they checked the unit refrigerators.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 40960 Based on record review and interviews, the facility failed to ensure mandatory submission of direct care staffing based on payroll data. Specifically, the facility failed to ensure staffing data entered in the Payroll-Based Journal (PBJ) system was accurate. Findings include: I. Record review The PBJ staffing report for quarter three (4/1/24 to 6/30/24) showed the following triggered areas: -Excessive low weekend staffing; and, -One star rating. The trigger for low weekend staffing triggered the facility's one star rating. -However, review of the facility's April 2024 to June 2024 staff time cards revealed the facility did not have low weekend staffing. II. Staff interview The nursing home administrator (NHA) was interviewed on 10/7/24 at 2:45 p.m. The NHA said the facility used a third party processor to submit their PBJ report. She said the third party processor did not submit the report timely and it was rejected. The NHA said the one star rating and the low weekend staffing triggers occurred because the report was not submitted timely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of three units. Specifically, the facility failed to: -Ensure housekeeping staff followed appropriate infection control procedures when cleaning and disinfecting residents' rooms and high frequency touched areas (call lights, door handles and handrails); -Ensure housekeeping staff followed disinfectant dwell times (amount of time required to ensure germs are eliminated) when cleaning residents' rooms; -Ensure housekeeping staff performed appropriate hand hygiene and changed gloves after cleaning residents' toilets; and, -Ensure staff wore the appropriate personal protective equipment (PPE) when administering medications through a feeding tube for a resident who was on Enhanced Barrier Precautions (EBP). Findings include: I. Housekeeping failures A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 10/9/24 from https.//pubmed.ncbi.nlm.nih.gov. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease). Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stays, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 10/9/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/pre (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ent/resource-limited/cleaning-procedures. html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. B. Facility policy and procedure The Cleaning and Disinfecting Resident Rooms policy and procedure, revised August 2013, was provided by the director of nursing (DON) on 10/7/24 at 3:20 p.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for cleaning and disinfecting resident rooms. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products. Floor mopping solution will be replaced every three resident rooms, or changed no less often than at 60 minute intervals. Resident room cleaning: -Gather supplies as needed; -Prepare disinfectant according to manufacturer's recommendations; -Discard disinfectant/detergent solutions that become soiled or clouded with dirt and grime and prepare fresh solution; -Change mop solution water at least every three (3) rooms, or as necessary; -Clean horizontal surfaces (bedside tables, overbed tables, and chairs) daily with a cloth moistened with disinfectant solution. Do not use feather dusters; and, -Clean personal use items (lights, phones, call bells, bed rails) with disinfectant solution at least twice weekly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Observations During a continuous observation on 10/7/24, beginning at 8:22 a.m. and ending at 8:44 a.m., housekeeper (HSK) #1 was observed cleaning room [ROOM NUMBER] and room [ROOM NUMBER]. HSK #1 removed a purple rag, a green rag, the toilet brush and a bottle of disinfectant from the cart. She entered room [ROOM NUMBER] and wiped the surfaces of the dresser and the bedside table with the purple rag. -HSK #1 did not use a disinfectant while cleaning the room or disinfect high touch areas such as the door knobs, light switches, call light and bed controller. HSK #1 entered the bathroom and sprayed the disinfectant on the counter and sink. She immediately wiped the surface off. HSK #1 sprayed the toilet rim and bowl with the disinfectant. She used the toilet brush to clean the inside of the toilet bowl and used the green rag to wipe the rim of the toilet. -HSK #1 failed to allow the disinfectant to remain on surfaces for the appropriate disinfectant dwell time. -HSK #1 failed to disinfect any other parts of the toilet, the bathroom grab bars, the shower, the light switch or the door knobs. HSK #1 placed the soiled rags and the disinfectant bottle in the cart. Without removing her gloves or performing hand hygiene, she removed two mop pads from a bucket on her cleaning cart and the mop handle. She dropped one of the mop pads on the floor by the door and one in the bathroom and proceeded to mop the resident's room and bathroom. -HSK #1 said there was no disinfectant in the mop pad bucket and it only contained plain water. -HSK #1 did not change her gloves or perform hand hygiene after cleaning the toilet before removing the mop pads from the bucket of plain water. After finishing the mopping in room [ROOM NUMBER], HSK #1 proceeded to room [ROOM NUMBER]. HSK #1 removed two green rags, the toilet brush and a bottle of disinfectant from the cart. She wiped the dresser and bedside table with the dry cloth. -HSK #1 did not use a disinfectant while cleaning the room or disinfect high touch areas such as the door knobs, light switches, call light and bed controller. HSK #1 entered the bathroom and sprayed the disinfectant on the counter and sink. She immediately wiped the surface off. HSK #1 sprayed the toilet rim and bowl with the disinfectant. She used the toilet brush to clean the inside of the toilet bowl and used the second green rag to wipe the toilet seat, the top of the tank, the tank, behind the seat, the rim and then the base of the toilet. -HSK #1 failed to allow the disinfectant to remain on surfaces for the appropriate disinfectant dwell time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HSK #1 failed to disinfect the toilet from top to bottom, the grab bars, the shower, the light switch or the door knobs. HSK #1 placed the soiled rags and the disinfectant bottle in the cart. Without removing her gloves or performing hand hygiene, she removed two mop pads from the bucket on her cleaning cart and the mop handle. She dropped one of the mop pads on the floor by the door and one in the bathroom. and proceeded to mop the resident's room and bathroom. -HSK #1 did not change her gloves or perform hand hygiene after cleaning the toilet before removing the mop pads from the bucket of plain water. D. Staff interviews HSK #1 was interviewed on 10/7/24 at 8:45 a.m. HSK #1 said she did not clean the bed because the resident never left the bed. She said she should have sprayed the rag with the disinfectant and immediately wiped it off. HSK #1 said she did not know what high touch surfaces were. She said she usually wore the same gloves through the entire cleaning process and did not know if a cleaner or disinfectant needed to be in the mop water. The housekeeping and laundry manager (HLM) was interviewed on 10/7/24 at 9:38 a.m. The HLM said HSK #1 should have cleaned the residents' rooms from clean to dirty and all surfaces, as well as high touch areas, should have been disinfected. The HLM said the disinfectant had a dwell time of one minute and should not be wiped off immediately. The HLM said surfaces should remain wet for a full minute before wiping in order to kill the pathogens that may be present. The HLM said HSK #1 should not have mopped the floor with plain water. The HLM said a disinfectant should have been mixed with the water in the mop bucket. The HLM said housekeepers should always change gloves and perform hand hygiene after cleaning the toilet. The HLM said based on the observation of HSK #1, hand hygiene was not adhered to, cleaning methods were not followed per the facility's procedures and the surface disinfectant times were not followed. The HLM said she would immediately educate the housekeepers on the proper techniques for room cleaning. The DON was interviewed on 10/7/24 at 10:39 a.m. The DON said every room should be cleaned and disinfected daily and the housekeepers should follow the manufacturer's recommended dwell time for the products to disinfect properly. The DON said gloves should be changed and hand hygiene performed after cleaning the bathroom. The DON said all high touch surfaces need to be cleaned daily, especially with the medically complex residents that resided at the facility. The DON said the residents' rooms should be cleaned from clean to dirty and top to bottom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The infection preventionist (IP) was interviewed on 10/7/24 at 12:45 p.m. The IP said the residents' rooms should be cleaned and disinfected daily, gloves should be changed after each task and a disinfectant needed to be used on all surfaces, including the floor. The IP said the toilet should be cleaned from clean to dirty and the disinfectant dwell times followed for infection control purposes. The IP said she would immediately re-educate the housekeeping staff on the facility's cleaning procedures, hand hygiene and the disinfectant dwell time. 47064 II. Failure to ensure staff wore appropriate PPE when administering medications through a feeding tube for a resident on EBP A. Facility policy and procedure The Enhanced Barrier Precautions (EBP) policy and procedure, dated 1/6/23, was received from the IP on 10/7/24 at 1:02 p.m. It read in pertinent part, EBP are utilized to prevent the spread of multidrug resistant organisms (MDROs) to residents. EBP employs targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing high-contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, and tracheostomy/ventilator)and complicated wound care (any skin opening requiring a dressing). EBP remains in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk as they can still serve as a source of transmission even after the infection has resolved. Staff are trained prior to caring for residents on EBP. Signs are posted on the door or wall outside the residents' rooms indicating the type of precautions and PPE required. PPE is available outside of the residents' rooms. The gown and gloves used for each resident during high-contact resident care activities should be removed and discarded after each resident care encounter. Hand hygiene should be performed, and new gown and gloves should be donned before caring for a different resident. B. Observations and staff interview (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/7/24 at 8:40 a.m. licensed practical nurse (LPN) #1 was administering medications to Resident #27. Resident #27 had a physician's order for medications to be administered via G-tube (gastrostomy tube - a tube inserted through the belly directly into the stomach). LPN #1 prepared all medications as ordered. LPN #1 went to Resident #27's room, knocked on the door and announced herself. There was a sign outside Resident #27's door that indicated the resident was on EBP. LPN #1 entered the resident's room, placed medications on the bed side table, performed hand hygiene with an alcohol based hand rub and applied clean gloves. LPN #1 collected water and a large syringe to administer the medications via the resident's G-tube. LPN #1 administered the medications as ordered. During administration of the medications, the G-tube was connected to a large syringe, bubbles were seen in the syringe and gurgling noises were heard as LPN #1 administered the medications. LPN #1 washed her hands with soap and water prior to exiting Resident #27's room. -LPN #1 failed to apply PPE, including a gown, mask, and face shield prior to the administration of Resident #27's medications via the G-tube. LPN #1 was interviewed immediately upon exiting Resident #27's room at 8:59 a.m. LPN #1 said she did not have to wear all of the PPE for medication administration via G-tube. She said the PPE was only required for Resident #27 when his wound care was being provided. C. Additional staff interviews LPN #3, who was also the unit manager, was interviewed on 10/7/24 at 10:18 a.m. LPN #3 said PPE, such as gowns, masks and gloves were required to be worn when administering medications via a G-tube to a resident on EBP. LPN #3 said the PPE was needed due to the increased risk of splashing from a G-tube. LPN #3 said the PPE was to be worn to help prevent the spread of infection. The DON was interviewed on 10/7/24 at 10:32 a.m. The DON said if medications were being administered to a resident on EBP via a G-tube, PPE, such as a gown, gloves and mask should be worn to prevent infection. The DON said the G-tube was an opening in the body which increased the risk of infection. The IP was interviewed on 10/7/24 at 12:50 p.m. The IP said PPE should be worn during medication administration via G-tube for a resident on EBP. The IP said a mask, gown and gloves were to be worn to help prevent the spread of infection. The IP said staff would be re-educated on EBP procedures.