STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A190	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Peaks Veterans Community Living Center	23500 US Highway 160 Walsenburg, CO 81089

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to ensure three (#65, #56 and #12) of three residents reviewed out of 28 sample residents were kept free from abuse. Specifically, the facility failed to: -Prevent a resident-to-resident altercation between Resident #65 and Resident #56; and, -Protect Resident #12 from physical abuse by Resident #65. Findings include: I. Facility policy and procedure The Abuse Prohibition policy and procedure, dated 8/1/18, was provided by the nursing home administrator (NHA) on 12/2/24 at 12:39 p.m. It read in pertinent part, It is the policy of this facility to make all efforts to protect its residents from abuse. The facility will periodically interview staff, residents and families to determine if there are any situations that could lead to a possible incident (staff stress, resident behaviors). The facility will educate staff and residents on how to avoid situations that may result in an abuse incident. The facility will educate staff and residents of possible incidents and allegations which need to be reported. This can be accomplished by role-playing or by using the training modules. Upon receiving a report of alleged abuse, the administrator or designee will ensure that a Report of Alleged Resident abuse Incident Report is completed. The administrator/designee will review the report to determine if reasonable cause exists to suspect abuse. If this is determined, the administrator/designee will convene the investigation team to begin the investigation following the appropriate abuse policy and procedure. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If suspected or actual abuse has been identified, the first step in the reporting process is to ensure residents' safety. Once a report of abuse and it has been determined there is reasonable suspicion, the following will occur: Resident-to-Resident: Separate residents. Contact law enforcement to remove the perpetrator if necessary. Monitor residents to ensure there are no further incidents. II. Failure to prevent a resident-to-resident altercation between Resident #65 and Resident #56 A. Facility investigation of the incident between Resident #65 and Resident #56 on 10/29/24 The facility's investigation of the 10/29/24 incident between Resident #65 and Resident #56 was provided by the director of nursing (DON) on 12/4/24 at 2:30 p.m. The investigation, dated 10/29/24 at 12:40 p.m., documented the following information: Resident #56 followed Resident #65 to his room. Licensed practical nurse (LPN) #2 reported she heard Resident #65 say Get out of here. LPN #2 entered Resident #65's room and saw Resident #56 and Resident #65 pushing each other. Resident #65 fell to his knees and Resident #56 was standing over Resident #65 trying to help him off the floor by his shirt. LPN #2 redirected Resident #56 out of Resident #65's room. Resident #56 had no injuries and Resident #65 had three small abrasions to his right elbow. Neither resident could recall or describe the incident. Both residents denied pain or fear of anyone. Resident #65 denied anyone entering his room or being in an altercation with anyone. Resident #56 was interviewed on 10/29/24 and had garbled speech and was not able to complete the interview. When asked what occurred in the room, Resident #56 had inappropriate verbal responses about another topic. Resident #65 was interviewed on 10/29/24 and when asked if someone entered his room, he said no. When asked if someone hurt him, he said no. When asked if someone pushed him, he said yes, and when asked if he pushed anyone, he said no. When asked if he was fearful of anyone he said no. When asked if he could explain what happened in his room, Resident #65 did not reply. The investigation indicated both Resident #56 and Resident #65 had a history of wandering, pacing, being territorial and a history of physical and verbal aggression toward staff. The conclusion of the internal investigation was the facility did not substantiate physical abuse as both residents had dementia. -However, Resident #65 sustained three small abrasions to his left elbow from the altercation, indicating abuse occurred. A. Resident #65 1. Resident status (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Resident #65, age 75, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included dementia with agitation, depression and post-traumatic stress disorder (PTSD).

The 8/14/24 minimum data set (MDS) assessment revealed the resident had short-term and long-term memory loss with severe cognitive impairment and severely impaired decision-making ability. He required dependent assistance with showering and bathing. He was independent with all other activities of daily living (ADL).

The assessment indicated Resident #65 had no physical or verbal behavioral symptoms directed towards others.

2. Record review

The short term and long-term memory care plan, revised on 5/30/24, documented Resident #65 had memory loss with severe cognitive impairment and severely impaired decision-making skills related to a diagnosis of dementia. Interventions included providing medications for the resident as ordered, monitoring for effectiveness and adverse reactions, keeping the physician and the resident's representative updated as needed, monitoring the resident for any increase in cognitive loss and informing the charge nurse and the social service director (SSD), providing the resident with clear explanations regarding expectations and procedures prior to proving any type of care or interventions and providing the resident with orientation to his immediate environment as needed.

The mood and behavior care plan, revised on 10/21/24, documented Resident #65 had a diagnosis of dementia with behaviors. Targeted behaviors included, verbal/physical aggression and cursing. Interventions included certified nurse aides (CNA) monitoring targeted behaviors/offering non-pharmacological interventions and reporting to nurse for documentation and assisting with interventions as needed, if resident was exhibiting negative behaviors, attempting to redirect him by offering one-on-one activity such as talking, walking, music, wheelchair rides, a quiet place to sit, assisting the resident to his room to rest, referring the resident to social services or outside resources as needed, calling his family as needed, providing medications as ordered and monitoring for effectiveness, keeping the physician and the resident's representative updated as needed, monitoring the resident for early signs of distress, such as agitated speech, cursing and/or angered expressions and attempting to de-escalate behaviors by decreasing stimulation, reapproaching later or spending one-on-one time with the resident.

-The care plan was not revised to include the incident with Resident #56 on 10/29/24.

Review of Resident #65's electronic medical record (EMR) revealed the following progress notes:

The 5/15/24 progress note documented Resident #65 was wandering the hallways and into other residents'rooms and when redirected he raised his hand to a CNA.

The 5/16/24 progress note documented Resident #65 was wandering into other residents' rooms and was found sleeping on one of the resident's beds.

(continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/29/24 progress note documented Resident #65 was walking around the unit barefoot and had no shirt on. When staff tried to assist the resident, he cursed at staff and went to his room and closed his door. The 6/21/24 progress note documented the nurse was checking Resident #65's blood sugar and when the nurse was done, the resident reached up and hit the nurse. When the nurse asked why he hit her he said because I can. The 8/20/24 progress note documented Resident #65 got into the staff charting room/breakroom and was going through the staff lunches. When staff approached the resident, he muttered an expletive and walked away. Later on in the morning, he was walking into the dining room and pushed the activity aide. The 8/29/24 progress note documented a CNA went into the resident's room to give him clean clothes and told the resident she was going to help him clean his room. Resident #65 grabbed the CNA by the face and raised his fist and told the CNA to Get the (explicit) out of my face. The 9/17/24 progress note documented Resident #65 was in the shower room with the bath aide. The nurse heard raised voices and the bath aide was heard saying Please don't hit me. Resident #65 declined to get dressed and attempted to hit the bath aide. Resident #65 was following the bath aide around the bathing room trying to hit her. The 10/1/24 progress note documented Resident #65 pushed a CNA as she was trying to pick up his belt from his robe as it was dragging on the floor. The 10/11/24 progress note documented Resident #65 became aggressive and physically assaultive towards the shower aide. Resident #65 was swinging at the shower aide with his fist. The shower aide was able to move out of the way to avoid contact. Resident #65 exited the bathing room naked and the DON attempted to redirect him and he physically assaulted her by hitting her in the arm and shoving her into the doorframe. The 10/11/24 progress note documented that during lunch Resident #65 grabbed a box of cookies and when staff got the box back, Resident #65 aggressively grabbed the cookies out of the staff members hand and left the dining room with the whole box. Resident #65 then came out of his room naked and was redirected back to his room. When staff redirected him back to his room Resident #65 poked the staff member on the side of her chest with his fingers in an aggressive manner. The 10/29/24 nursing progress note documented the medication nurse reported she heard Resident #65 say, Get out of here. She saw Resident #56 going into Resident #65's room. When the nurse entered Resident #65's room, she saw both residents pushing each other. Resident #65 fell to his knees and Resident #56 was standing over Resident #65 trying to pull Resident #65 up by his shirt. The nurse redirected Resident #56 out of Resident #65's room. Both residents were placed on one-on-one supervision and close monitoring for a few hours post-incident. The 10/30/24 interdisciplinary team (IDT) meeting note documented the altercation between Resident #56 and Resident #65 was reviewed. Interventions implemented in response to the incident included redirecting others away from Resident #65's room, giving direction for Resident #65 to avoid hitting or shoving others and providing close monitoring and one-to-one supervision as needed. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The 11/15/24 nursing progress documented CNA #9 reported that she heard Resident #12 say Hey, hey then saw Resident #65 punch Resident #12 with his right fist to Resident #12's cheek. Resident #12 was in the hallway, just before the entrance to the dining room. Resident #65 had gone into the dining room and when coming back out, Resident #65 tried to punch Resident #12, then proceeded to punch Resident #12 again and made contact to Resident #12's left cheek. CNA #9 intervened to keep the residents separated. When asked what happened, Resident #65 closed his eyes and did not answer. When the nurse asked Resident #65 if he had hit anyone, Resident #65 kept his eyes closed and shook his head side to side for no (see incident between Resident #65 and Resident #12 below).

B. Resident #56

1. Resident status

Resident #56, age less than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included Alzheimer's disease, dementia and depression.

The 10/9/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of zero out of 15. He required dependent assistance with oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene.

2. Record review

The care plan for agitation, revised on 10/21/24, documented Resident #56 had a diagnosis of dementia with agitation and was on antipsychotic medication. He was also prescribed an anticonvulsant for his behaviors. Targeted behaviors included hallucinations, delusional thinking, verbal and physical aggression, agitated pacing, paranoia, irritability and invading others' personal space. Interventions included CNAs monitoring targeted behaviors/offering non-pharmacological interventions and reporting to nurse for documentation and assisting with interventions as needed, if resident was exhibiting negative behaviors, staff was to attempt to redirect him by offering one-on-one activity such as talking, walking, music, wheelchair rides, a quiet place to sit, assisting the resident to his room to rest, referring resident to social services or outside resources as needed, monitoring resident for any changes in his behaviors, such as lethargy, dizziness, falls, yelling and/or hitting out, crying, isolation, changes in eating habits, weight changes, monitoring resident for early signs of distress, such as agitated speech, cursing and/or angered expression and attempt to de-escalate behaviors by decreasing stimulation, reapproaching later or spending one-on-one time with the resident.

(continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan for behaviors, revised on 9/30/24, documented Resident #56 had a history and potential to display behaviors related to his Alzheimer's dementia. Resident #56 could display territorial behaviors, verbal aggression, irritability, agitated pacing, invading personal space, paranoia, delusional thoughts, increased frustration related to difficulty expressing self, anxiousness about missing his wife and dog. Triggers identified from past incidents and history included touching the resident and grabbing things from the resident, blocking the resident in a blocking motion or cutting him off, interrupting the resident, arguing with the resident, trying to staff not acknowledging him, telling the resident no or you can not do that. Interventions included allowing the resident time to communicate, avoiding rushing the resident, validating feelings, showing empathy, when invading others' personal, space-step back and avoid talking abruptly and avoid touching the resident, when resident was agitated with rapid speech and hand gesture and in others' personal, space step back, if resident took something, allowing him time to put it down, asking him kindly to have the item back but not reaching for it or taking it from him, if resident exited a door, asking the resident if he would like to go for a walk in whatever direction he was heading, avoiding grabbing or blocking him as this triggered his agitation, avoiding overcrowding the resident when he was agitated, if staff was a known trigger, avoiding interaction with the resident for that day, taking the resident for walks and outdoors, talking about the [NAME] Bay Packers, Bigfoot and giving him ice cream, talking about dogs, redirecting the resident with topics of interest, allowing the resident to express himself and listening to him, if the resident was angry, asking if he would like to get a diet Pepsi, CNAs monitoring targeted behaviors/offering non-pharmacological interventions and reporting to nurse for documentation and assisting with interventions as needed, if resident was exhibiting negative behaviors attempt to redirect him by offering one-on-one activity such as talking, walking, music, wheelchair rides, a quiet place to sit, assisting him to his room to rest and referring resident to social services or outside resources as needed, monitoring environment for possible stressors, monitoring resident for any changes in his behaviors such as lethargy, dizziness, falls, yelling and/or hitting out, crying, isolation, changes in eating habits, weight changes, notifying charge nurse, physician and representative as needed and monitoring the resident for early signs of distress such as agitated speech, cursing and/or angered expression and attempting to de-escalate behaviors by decreasing stimulation and reapproaching later or spending one-on-one time with the resident. The 10/29/24 nursing progress note documented the medication nurse reported she heard Resident #65 say, Get out of here. She saw Resident #56 going into Resident #65's room. When the nurse entered Resident #65's room, she saw both residents pushing each other. Resident #65 fell to his knees and Resident #56 was standing over Resident #65 trying to pull Resident #65 up by his shirt. The nurse redirected Resident #56 out of Resident #65's room. Both residents were placed on one-on-one supervision and close monitoring for a few hours post-incident. The 10/30/24 interdisciplinary team (IDT) meeting note documented the altercation between Resident #56 and Resident #65 was reviewed and the physical aggression between Resident #56 was initiated by Resident 65. Interventions included giving boundaries that were consistent with telling Resident #56 that when a door was closed, he should not enter, assisting the resident with redirection, closely monitoring the resident and one-on-one supervision as needed. III. Failure to protect Resident #12 from physical abuse by Resident #65 A. Facility investigation of the incident of physical abuse by Resident #65 toward Resident #12 on 11/15/24 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Spanish Peaks Veterans Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 23500 US Highway 160 Walsenburg, CO 81089	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's investigation of the 11/15/24 incident between Resident #12 and Resident #65 was provided by the DON on 12/5/24 at 12:30 p.m. The investigation, dated 11/15/24 at 10:43 a.m., documented the following information: Resident #65 had gone into the dining room and when he came out into the hallway he punched Resident #12. Resident #12 was heard saying, Hey, hey which alerted CNA #9. CNA #9 saw Resident #65 punch Resident #12 with his right fist to Resident #12's left cheek. CNA #9 immediately separated both residents. Resident #65 was placed on one-to-one supervision immediately. Resident #65 was interviewed on 11/15/24 and refused to answer questions about the incident. Resident #12 was interviewed on 11/15/24 and was non-verbal. Resident #12 did not answer questions and had no changes in behavior. The investigation indicated Resident #65 had a history of aggressive behaviors and recent assault on Resident #12, which was unprovoked. The conclusion of the investigation was that the facility substantiated the physical abuse. B. Resident #12 1. Resident status Resident #12, age 79, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included neurocognitive disorder with Lewy bodies dementia (causes a gradual decline in thinking abilities, especially in attention, visual perception and executive function) and anoxic brain damage. The 10/2/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of zero out of 15. He required dependent assistance with all ADLs. According to the MDS assessment, Resident #12 had no physical or behavioral symptoms directed towards others. 2. Record review The care plan for dementia, revised on 3/15/23, documented Resident #12 had a diagnosis of dementia with depression. He had a history of irritability, weight loss, social isolation and flat affect. Interventions included encouraging the resident to express his/her feelings with nursing and social services, keeping the physician and representative informed of all significant findings and changes, monitoring the resident for signs or symptoms of depression, such as crying, verbalizations of sadness, isolation, changes in eating habits, changes in weight, agitation, increased sleeping, reporting any significant findings to charge nurse for assessment and follow-up, monitoring the resident's environment for possible stressors and referring to social service director and/or outside resources as needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan for PTSD (post-traumatic stress disorder), revised on 10/9/23, documented Resident #12 had potential for injury to self and others related to diagnosis of and history of PTSD. Interventions included approaching Resident #12 in a calm friendly manner, when approaching the resident, staff was to always tell him their name and why they were there, explaining what staff would like to do prior to giving any care, monitoring the resident for increases in negative behaviors and reporting any significant findings to charge nurse, providing resident one-to-one quiet discussion if he was willing, attempting to find quiet areas for the resident to sit when he was agitated, referring to social service director as needed, referring resident to outside resources if needed, reorienting the resident to his environment and the people around him and reassuring him of his safety. The 11/15/24 progress note documented CNA #9 reported that she heard, Hey, hey, then saw Resident #65 punch Resident #12 with his right fist to Resident #12's cheek. Resident #12 was in the hallway, just before the entrance to the dining room. Resident #65 had gone into the dining room and when coming back out, Resident #65 tried to punch Resident #12, then proceeded to punch Resident #12 again and made contact to Resident #12's left cheek. CNA #9 intervened to keep the residents separated. Resident #12 was able to move his face and there was no noted discoloration, no grimace or other signs of pain. Resident #12 was unable to give a description of the incident. Resident #12 was immediately moved away from the hallway and placed in the dayroom for his own protection. The 11/18/24 IDT meeting note documented the incident of physical aggression was reviewed. Interventions included keeping pathways clear, monitoring the assailant for further behaviors, close monitoring of all residents and monitoring Resident #12 for any psychosocial harm, fear or injury. IV. Staff interviews LPN #2 was interviewed on 12/5/24 at 10:10 a.m. LPN #2 said she was not working when both incidents involving Resident #65 occurred. She said when she returned to work, she was informed that Resident #65 had been violent towards another resident. She said Resident #65 had never been violent towards other residents. She said Resident #65 had been agitated and verbally aggressive towards staff, but not residents. LPN #2 said prior to the abuse incidents, Resident #65, Resident #56 and Resident #12 had had no interactions with each other. She said Resident #65 did his own thing and would only see Resident #56 and Resident #12 in passing during meal times. She said Resident #65 stayed in his room a lot and would come out when he was hungry or needed something. LPN #2 said Resident #65 was non-compliant, stubborn and had no social boundaries. She said Resident #65 had no awareness of his behaviors and did not care. LPN #2 said when Resident #65 was not following directions, she would provide continuous education to Resident #65 and notify him that other residents lived in the facility too. She said she would constantly coach Resident #65 on having boundaries. Registered nurse (RN) #7 was interviewed on 12/5/24 at 11:17 a.m. RN #7 said Resident #65 and Resident #56 had no prior behaviors towards each other. She said Resident #65 had been aggressive towards staff in the past but had not been aggressive towards other residents. She said Resident #65 would come into the staff's space and get close to the staff's faces. She said staff would redirect Resident #65 and back out of his way when he got too close. (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review and interviews, the facility failed to provide adequate supervision and an environment as free from accidents hazards as possible for two (#4 and #24) of 18 residents reviewed for accident hazards out of 28 sample residents. Specifically, the facility failed to: -Ensure scissors were not available for Resident #4 to use and prevent injury to Resident #4 when he attempted to cut his fingernails with the scissors; -Ensure essential oils were not left unsecured in Resident #4's room, who was not assessed for self-administration; and, -Ensure hydrocortisone cream was not left unsecured in Resident #24's room, who was not assessed to self-administer this medication. Findings include: I. Failure to ensure scissors were not available for Resident #4 to use and prevent injury to Resident #4 when he attempted to cut his fingernails with the scissors. A. Resident #4 1. Resident status Resident #4, age 78, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO) diagnoses included type 2 diabetes mellitus, stage 5 chronic kidney disease (end stage), dependence on renal dialysis (the process of removing excess fluid and waste from the blood when the kidneys are not functioning) and acquired absence of right and left legs below the knee (amputations). The 10/9/24 minimum data set (MDS) assessment revealed Resident #4 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. He required total assistance from staff for transfers, partial assistance with dressing and propelled himself in a wheelchair. Resident #4 was independent with eating. 2. Observation and resident interview Resident #4 was interviewed on 12/2/24 at 2:16 p.m. He was sitting in his wheelchair in his room. He had bandaids on his thumb and two fingers on his left hand. Resident #4 said he found nail clippers in his room and he started clipping his fingernails this morning (12/2/24). He said he got too close and his fingers started bleeding so the nurse put bandaids on his fingers. 3. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A skin assessment, dated 12/3/24 at 6:07 p.m., documented Resident #4 had cut his fingernails on the left hand cutting the skin on his nailbed. -The assessment did not indicate which or how many fingers were affected or if treatment was provided. An incident report was completed on 12/4/24 at 1:25 p.m. regarding Resident #4's injuries to the fingers on his left hand. The report documented corrective action was to educate the resident to not cut his fingernails himself, but to ask for assistance from the nurse. -However, Resident #4 had bandaids on his fingers when interviewed on 12/2/24 at 2:16 p.m. and stated he tried to cut his fingernails on 12/2/24. A skin assessment was not documented until 12/3/24 and the incident report was not completed until 12/4/24. A nursing progress note, dated 12/4/24 at 1:28 p.m., documented Resident #4 tried to cut his fingernails on his left hand and cut his nails too close to the nail bed. Resident #4 was diabetic. The nurse clipped nails on the right hand. D. Staff interviews The NHA was interviewed on 12/3/24 at 4:05 p.m. via email. The NHA said that the nurses were the only staff allowed to trim nails for diabetic residents. LPN #4 was interviewed on 12/4/24 at 10:02 a.m. LPN #4 said Resident #4 tried to cut his fingernails with scissors that he had in his room. LPN #4 said she did not know where he got the scissors, but he must have taken them from somewhere. LPN #4 said after he cut the skin on his left hand he let the nurse trim his nails on the right hand. LPN #4 said the nurses trimmed fingernails for residents with diabetes. She said the residents should not cut their own fingernails. The NHA was interviewed on 12/5/24 at 10:37 a.m. The NHA said the nurse should have documented Resident #4's skin injury when it happened, reported the incident to the charge nurse and completed an incident report immediately. The NHA said she had no knowledge of this incident until 12/5/24 after receiving the incident report that was completed on 12/4/24. The DON was interviewed on 12/5/24 10:45 a.m. The DON said the interdisciplinary team (IDT) reviewed the incident report for Resident #4 and recommended the nurse check Resident #4's fingernails weekly on his skin assessment days and offer to trim them for him to prevent further injury. III. Failure to ensure essential oils were not left unsecured in Resident #4's room, who did not have an assessment for self-administration. A. Facility policy and procedure The Self Administration of Medication policy, revised September 2019, was provided by the nursing home administrator (NHA) on 12/5/24 at 11:53 a.m. It read in pertinent part, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents will be assessed for their ability to self-administer medications on admission. A physician order must be written permitting the resident to self-administer medications. The resident must verbalize understanding of his/her medication schedule and demonstrate appropriate techniques. The resident must demonstrate the ability to keep the medication locked and secured, not left out within vision or access of others. Only those medications which have been approved for bedside use may be kept at the bedside. All other medication will be kept in the medication or treatment cart at the nurse's station. The Storage and Expiration of Medications, Biologicals, Syringes and Needles policy and procedure, revised 1/1/13, was provided by the NHA on 12/5/24 at 1:55 p.m. It read in pertinent part, The facility should ensure that all medications and biologicals, including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. The facility should store bedside medications or biologicals in a locked compartment within the resident's room. A. Manufacturer Safety Data Sheets (SDS) The SDS for Pink Peppercorn (Schinus [NAME] oil), dated 12/21/21, was retrieved on 12/10/24 from https://www.nhrorganicoils.com/uploads/20220119110320e_Pepper_Brazilian_SDS.pdf. The SDS revealed the product may cause skin irritation, allergic skin reactions, eye irritation and may be fatal if swallowed or entered into the airway. The SDS for Copaiba Oleoresin oil, dated 10/21/22, was retrieved on 12/10/24 from https://www.nhrorganicoils.com/uploads/20221103132608e_Copaiba_Balsam_SDS.pdf. The SDS revealed the product may cause mild skin irritation, allergic skin reactions and may be fatal if swallowed or entered into the airway. The SDS for Frankincense essential oil, dated 12/14/16, was retrieved on 12/10/24 from https://www.nhrorganicoils.com/uploads/20170607122732e_Frankincense_SDS.pdf. The SDS revealed the product may cause skin irritation, allergic skin reaction and may be fatal if swallowed or entered into the airway. B. Resident observation and interview Resident #4 was interviewed on 12/2/24 at 2:16 p.m. Resident #4 was sitting in his wheelchair in his room. Resident #4 said he had some oils that a family member told him to try for pain and memory. He pulled out three small bottles from an empty procedure glove box sitting on top of his night stand. The bottles were labeled Organic Copaiba Oleoresin, Pink Peppercorn and Frankincense. He said he was not sure how to use them but his family was supposed to come in and show him. C. Record review A review of the December 2024 physician's orders did not include the essential oils found in his room. There was not a physician's order for Resident #4 to self-administer medications or essential oils. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record included an incomplete assessment for self-administration of medication, dated 4/3/23, which documented Resident #4 was not interested in self-administering medication. D. Staff interviews The NHA was interviewed on 12/3/24 at 2:39 p.m. via email. The NHA said Resident #4 did not have a self-administration assessment for the essential oils. The NHA said Resident #4 ordered the oils on his own and the staff were unaware he had them in his room. The NHA said the oils were removed from his room and an evaluation was in process to determine if he could self-administer them and store them in his room. The NHA said a policy would be created regarding the use of essential oils. The DON was interviewed on 12/5/24 at 10:45 a.m. The DON said the facility did have a policy for essential oils but it was outdated. The DON said they were evaluating the essential oils and safety for Resident #4's use. The DON said the activities staff would be asked to alert nursing staff when residents got packages so the nurse could be there when they opened them and ensure the products received would not be an accident hazard. IV. Failure to ensure medication was not left unsecured in Resident #24's room. A. Resident status Resident #24, age 76, was admitted on [DATE]. According to the December 2024 CPO diagnoses included chronic obstructive pulmonary disease (damage to the airways or lungs making it difficult to breathe), schizoaffective disorder (a chronic mental illness combining schizophrenia and a mood disorder), hypertension (high blood pressure), cervical disc disorder at C5-C6 level (neck area) with myelopathy (pain, loss of feeling or function resulting from severe compression of the spine) and post-traumatic stress disorder. The 9/25/24 MDS assessment revealed Resident #24 was cognitively intact with a BIMS score of 15 out of 15. He required assistance from one staff member for transfers from bed to wheelchair and for dressing. Resident #24 was independent with transfers to the toilet and with personal hygiene. B. Resident interview and observation Resident #24 was interviewed on 12/2/24 at 2:35 p.m. Resident #24 was lying in bed. There was a tube of hydrocortisone cream on his bedside table. Resident #24 said he was using it because he had a rash. He said he did not know why it was left on his table. Resident #24 said the nurse put the cream on for him. C. Record review The comprehensive care plan, initiated on 11/17/16 and revised on 8/7/19, revealed Resident #24 was not a candidate for self-administration of medication and had a history of pocketing (holding inside the cheek) medications. Interventions included watching Resident #24 swallow his medication, reminding Resident #24 of the need to take medications while the nurse was present and monitoring Resident #24's room for medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #24 electronic medical record (EMR) did not reveal an assessment for the self-administration of hydrocortisone cream had been completed. The December 2024 CPO included a physician's order for hydrocortisone external cream 1%, applied to areas of dry, itchy skin topically, every 12 hours as needed, ordered on 10/2/24. -A review of the December 2024 CPO did not reveal a physician's order for the self-administration of the hydrocortisone external cream. A review of the November 2024 and December 2024 MAR revealed the hydrocortisone cream was last administered to Resident #24 on 11/23/24, nine days prior to being observed in Resident #24's room. D. Staff interviews Certified nurse aide (CNA) #7 was interviewed on 12/5/24 at 1:30 p.m. CNA #7 said if she found a medication or a cream in a resident's room she would turn it in to the nurse immediately. Registered nurse (RN) #2 was interviewed on 12/5/24 at 1:31 p.m. RN #2 said Resident #24 did not keep medication in his room. She said at times he tried to get the nurses to leave medication on his table. RN #2 said she did not know why the hydrocortisone cream was left in his room because it was ordered as needed and it had not been administered in several days. The DON was interviewed on 12/5/24 at 12:00 p.m. The DON said Resident #24 should not have hydrocortisone cream at his bedside. The DON said Resident #24 needed help administering it and it must have been left in his room by accident. The DON said it was removed from his room after being discovered on 12/2/24 and the nurses were re-educated to check his room for medications.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review, observations and interviews, the facility failed to ensure a through safety assessment was completed and documented before the installation of side/bed rails for four (#70, #57, #63 and #38) of 10 residents out of 28 sample residents. Specifically, for Residents #70, #57, #63 and #38, the facility failed to: -Ensure the residents were thoroughly assessed prior to the installation of bed rails, to include the residents' medical diagnoses, conditions, symptoms and/or behavioral symptoms, size and weight, sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication and mobility (in and out of bed); and, -Evaluate the use of alternative interventions prior to the installation or use of a bed rail and how those alternatives failed to meet the residents' assessed needs. Findings include: I. Facility policy and procedures The Devices - Restraints/Safety/Positioning/Mobility Devices policy, reviewed on 6/2020, was provided by the nursing home administrator (NHA) on 12/4/24 at 1:58 p.m. The policy revealed residents were assessed for the need of a device and/or restraint in an appropriate environment to maintain the dignity, quality of life, safety and mobility in the least restrictive manner. A physician's order was required for use of physical devices or restraints. The order would indicate the type of device/restraint, and the purpose for the restraint or device. The resident and their responsible parties would be educated regarding the benefits and potential risks or injury of the usage of a restraint and/or device. A consent would be obtained from the resident or their responsible party. Devices or restraints were indicated for safety or enabling and improving the resident's mobility. Before a restraint was considered, all other less restrictive alternatives and interventions should be considered. Documentation would be maintained for each resident that addressed current restraints and/or devices in use. Documentation would include the need for the device, related to behavior or medical condition and its effectiveness. All devices and/or restraints would be reviewed at scheduled device review meetings. Placement of side rails or transfer bars would be monitored for risk of entrapment routinely by maintenance. A safety evaluation would be completed by occupational therapy (OT) and/or physical therapy (PT) on transfer aides and motorized wheelchairs that they recommend and evaluated for the right appropriate device for mobility and safety. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Resident # 70 A. Resident status Resident #70, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included alcoholic cirrhosis of the liver with ascites, tremors, unsteadiness on feet and mild cognitive impairment. The 8/28/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) score of 11 out of 15. The MDS assessment indicated the resident was independent without staff assistance for rolling left to right, sitting to lying, lying or sitting on the side of the bed and sitting to standing. B. Observations On 12/2/24 at 1:43 p.m., there were two-quarter side rails on Resident #70's bed. On 12/4/24 at 2:26 p.m., there were two-quarter side rails on the resident's bed. C. Record review A physician's order dated 7/29/24 at 2:30 p.m. revealed to install two transfer bars (bed rails) for mobility to Resident #70's bed. Resident #70 signed a Transfer Bar Consent form dated 7/29/24 at 2:29 p.m. The reason for the transfer bars was to assist the resident with mobility. The potential risks were explained to the resident. Potential risks might include accidental injury due to head and neck entrapment that could result in death, injury from falls/bumping transfer bars, and loss of independence in mobility. -However, the physical therapy assessment section of the consent form was blank and did not reveal that an assessment had been conducted to determine if Resident #70 would safely benefit from the implementation of the side rails. The risk for injury/falls care plan, initiated 8/25/24 and revised 9/30/24, revealed Resident #70 was at risk for injury/falls related to impaired mobility, episodes of increased confusion since readmission, history of falls, short-term memory deficit and poor safety awareness. -The care plan did not include the resident utilized bed rails on the bed for mobility and/or transfers. Resident #70 had one bed rail device review dated 11/27/24 related to the use of two transfer bars (bed rails) on the bed for assistance with bed mobility and transfer safety. The review did not recommend any changes needed to be made. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident #70's electronic medical record (EMR) revealed no documentation to indicate the resident was thoroughly assessed prior to the installation of the bed rails to include the resident's medical diagnoses, conditions, symptoms and/or behavioral symptoms, size and weight, sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication and mobility (in and out of bed). -Further review of Resident #70's EMR revealed there was no documentation to indicate what alternatives to bed rails were attempted prior to the installation of the bed rails or how those alternatives failed to meet the resident's assessed needs. III. Resident #57 A. Resident status Resident #57, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included dementia with agitation, and frontotemporal neurocognitive disorder. The 11/13/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15. The MDS assessment indicated the resident was given partial/moderate staff assistance for rolling left to right, sitting to lying, lying or sitting on the side of the bed and sitting to standing. B. Observations On 12/2/24 at 1:52 p.m., there were half-side bed rails on both sides of Resident #57's bed. On 12/4/24 at 2:31 p.m., Resident #57 was lying in the middle of the bed on his back. The bed had two half-side bed rails on the bed. C. Record review A physician's order dated 8/10/23 at 12:08 p.m., revealed to install two transfer bars (bed rails) for mobility to Resident #57's bed. Resident #57 signed a Transfer Bar Consent form dated 8/10/23 at 12:08 p.m. The reason for the transfer bars was to assist the resident with mobility. The potential risks were explained to the resident. Potential risks might include accidental injury due to head and neck entrapment that could result in death, injury from falls/bumping transfer bars, and loss of independence in mobility. The physical therapy assessment portion of the form revealed the resident was appropriate to have and use a transfer bar on the bed. -However, the physical therapy assessment did not reveal whether or not Resident #57's medical diagnoses, conditions, symptoms and/or behavioral symptoms, size and weight, sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication and mobility (in and out of bed) were included as part of the assessment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The risk for injury/falls care, initiated on 8/10/23 and revised on 8/10/23, revealed Resident #57 was at risk for injury/falls related to impaired mobility, history of falls, bowel incontinence and pain and muscle relaxant medications. Interventions included two transfer bars (bed rails) on the resident's bed to help with turning/positioning and to provide stability when rising. Resident #57 had six bed rail device reviews for bed rails from 8/22/23 to 11/27/24 related to the use of two transfer bars (bed rails) on the bed for assistance with bed mobility and transfers. The reviews did not recommend any changes needed to be made. -Review of Resident #57's EMR revealed no documentation to indicate the resident was thoroughly assessed prior to the installation of the bed rails to include the resident's medical diagnoses, conditions, symptoms and/or behavioral symptoms size and weight sleep habits medication(s) acute medical or surgical interventions underlying medical conditions existence of delirium ability to toilet self safely communication and mobility (in and out of bed). -Further review of Resident #57's EMR revealed there was no documentation to indicate what alternatives to bed rails were attempted prior to the installation of the bed rails or how those alternatives failed to meet the resident's assessed needs. IV. Resident #63 A. Resident status Resident #63, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included a closed fracture of the neck of the right femur, unsteadiness on feet, dementia and neurocognitive disorder with Lewy Bodies (progressive brain disease that affects mood, behavior and movement). The 11/6/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of three out of 15. The MDS assessment indicated the resident was dependent on staff for assistance. The staff provided all of the effort and the resident did none of the effort to complete the activity or the assistance of two staff members was required for the resident to complete the activity for rolling left to right, sitting to lying, lying or sitting on the side of the bed and sitting to standing. B. Observations On 12/2/24 at 12:44 p.m. there were two-quarter side bed rails on Resident #63's bed. On 12/4/24 at 2:28 p.m. there were two-quarter side bed rails on the resident's bed. C. Record review A physician's order dated 11/27/24 at 9:26 a.m., revealed to install two transfer bars (bed rails) for mobility to Resident #63's bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #63's representative signed a Transfer Bar Consent form dated 11/27/24 at 9:26 a.m. The reason for the transfer bars was to assist the resident with mobility. The potential risks were explained to the representative. Potential risks might include accidental injury due to head and neck entrapment that could result in death, injury from falls/bumping transfer bars, and loss of independence in mobility. The physical therapy assessment portion of the form revealed the resident demonstrated appropriate motor control with environmental awareness to safely use and benefit from transfer bars to help with bed mobility and balance. -However, the physical therapy assessment did not reveal whether or not Resident #63's medical diagnoses, conditions, symptoms and/or behavioral symptoms, size and weight, sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication and mobility (in and out of bed) were included as part of the assessment. The risk for injury/falls care plan, initiate 8/14/24 and revised 9/12/24, revealed Resident #63 was at risk for injury/falls related to impaired mobility, poor vision, psychotropic medication use, a history of falls, short term memory deficit, poor safety awareness and an unsteady gait. Interventions included two transfer bars (bed rails) on the resident's bed to help with turning, positioning and to provide stability when rising. Resident #63 had one bed rail device review dated 11/27/24 related to the use of two transfer bars bed rails on the bed for assistance with bed mobility and transfers. The review did not recommend any changes needed to be made. -Review of Resident #63's EMR revealed no documentation to indicate the resident was thoroughly assessed prior to the installation of the bed rails to include the resident's medical diagnoses, conditions, symptoms and/or behavioral symptoms, size and weight; sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication, and mobility (in and out of bed). -Further review of Resident #63's EMR revealed there was no documentation to indicate what alternatives to bed rails were attempted prior to the installation of the bed rails or how those alternatives failed to meet the resident's assessed needs. V. Resident #38 A. Resident status Resident #38, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included Alzheimer's disease and dementia. The 10/16/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of six out of 15. She required dependent assistance with all activities of daily living (ADL). B. Observations On 12/3/24 at 9:27 a.m. Resident #38's bed had two quarter size bed rails attached to the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 12:30 p.m. Resident #38's bed rails had an approximate three inch gap between the mattress and the bed rails and the bed rails were not tightly fastened. C. Record review The fall care plan, revised 8/16/23, documented, Resident #38 was at risk for injury/falls related to impaired mobility, poor vision, psychotropic drug use, history of falls, short-term memory deficit and poor safety awareness. Interventions included transfer bars (bed rails) on the bed times two to assist with mobility. Review of Resident #38's December 2024 CPO revealed the following physician's order: Transfer bars (bed rails) times two for bed mobility and transfers, ordered 3/7/23. The 3/7/23 Transfer Bar Consent form documented in the physical therapy assessment section of the form that Resident #38 was safe with the use of her transfer bars to assist with bed mobility and transfers. -Review of Resident #38's EMR revealed no documentation to indicate the resident was thoroughly assessed prior to the installation of the bed rails to include the resident's medical diagnoses, conditions, symptoms and/or behavioral symptoms, size and weight, sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication and mobility (in and out of bed). -Further review of Resident #38's EMR revealed there was no documentation to indicate what alternatives to bed rails were attempted prior to the installation of the bed rails or how those alternatives failed to meet the resident's assessed needs. D. Staff interview Certified nurse aide (CNA) #6 was interviewed on 12/5/24 at 12:08 p.m. CNA #6 said Resident #38 used her transfer bars (bed rails) for turning in bed and when sitting up in bed. CNA #6 said the staff asked Resident #38 to grab onto the bed rail and she would usually help the staff with turning her. VI. Additional staff interviews The director of rehabilitation (DOR) was interviewed on 12/5/24 at 9:50 a.m. The DOR said a physical therapy assessment for the use of transfer bars (bed rails) included an assessment of the resident's ability to use the transfer bar for mobility and to be able to transfer safely. The DOR said the assessment included the function of the resident's hands to be able to grasp the bed rails, and an evaluation of the resident's strength to help in positioning and/or the ability to use the device to help in a safe transfer. The DOR said the therapist also considered the safety of the bed rails and evaluated any safety concerns, including entrapment, and would document any concerns. The DOR said the therapist assessed the resident's size in relation to the bed and the mattress in relation to the size of the bed frame. The DOR said the therapist also looked at the resident's ability to move, reposition or offload in bed. The DOR said the facility did a thorough safety assessment for the use of a side/bed rail before its installation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Peaks Veterans Community Living Center	23500 US Highway 160 Walsenburg, CO 81089

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DOR said the therapist did not use a specific side/bed rail safety assessment form to address all of the items that were assessed. The DOR said the therapist's assessment/recommendations were included in the physical therapy assessment section on the Transfer Bar Consent form. -However, the Transfer Bar Consent form for Resident #70 failed to document that a physical therapy assessment was conducted and the Transfer Bar Consent forms for Resident #57, Resident #63 and #38 failed to document what specific components related to the residents were assessed in determining the residents were safe to utilize bed rails (see record review above). The NHA and the director of nursing (DON) were interviewed on 12/5/24 at 2:30 p.m. The DON said the facility felt they did an adequate safety assessment for each resident prior to the installation of the transfer bars (bed rails). The DON said the facility staff thoroughly assessed each resident for medical diagnosis, conditions, symptoms and/or behavioral symptoms, size and weight, sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication and mobility (in and out of bed). -However, review of the EMRs for Residents #70, #57, #63 and #38 failed to reveal documentation that each resident was assessed for all of the components prior to installation of their bed rails (see record review above). The DON said the staff knew each resident very well and knew the alternatives that were attempted prior to the installation of the bed rails and how those alternatives failed to meet the resident's assessed needs. -However, review of the EMRs for Residents #70, #57, #63 and #38 failed to reveal documentation that alternatives to bed rails were attempted for each resident prior to the installation of the bed rails or how those alternatives failed to meet each residents' needs (see record review above). The NHA said the facility was unable to provide sufficient evidence to demonstrate that a thorough safety assessment had been completed for the use of side/bed rails for mobility, position and transfers. The NHA said once the issue had been identified on 12/4/24 (during the survey), the facility took it upon themselves to complete a 100% audit of all residents with side/bed rails. The NHA said the facility completed and documented side/bed rail safety assessments that included medical diagnosis, conditions, symptoms and/or behavioral symptoms; size and weight, sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication and mobility (in and out of bed). The NHA said the facility also observed all residents' beds to ensure there were no residents that had undocumented side/bed rails. The DON said she had worked in the facility for [AGE] years and the facility had never had any concerns/issues with the use of side/bed rails. 48114

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review and interviews, the facility failed to ensure one (#4) of five residents out of 28 sample residents was free from significant medication errors. Specifically, the facility failed to: -Ensure insulin was not given when Resident #4's blood glucose (sugar) level was below the parameter for administration; -Ensure insulin was consistently administered for Resident #4; and, -Ensure Resident #4 had physician orders for what to do if the resident's blood glucose was too high (hyperglycemia). Findings include: I. Professional reference According to [NAME], P.A. and [NAME], A.G. et.al., (2020), Fundamentals of Nursing, ninth edition, pp 624 - 626, Medication errors can cause or lead to inappropriate medication use or patient harm. Medication errors include inaccurate prescribing, administration of the wrong medication, giving the medication using the wrong route or time interval. Administering extra doses, and/or failing to administer medications. Preventing medication errors is essential. Professional standards such as scope of nursing and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medication: the right medication, the right dose, the right patient, the right route, the right time and the right documentation. II. Facility policy and procedure The Medication Administration policy, dated 11/17/19, was provided by the nursing home administrator (NHA) on 12/5/24 at 11:53 a.m. It read in pertinent part, The nurse will administer the right medication to the right patient, at the right time, via the right dose, right route and right reason according to the manufacturer's specifications. The Diabetic Management policy, dated 6/1/2020, was provided by the NHA on 12/5/24 at 11:53 a.m. It read in pertinent part, Upon admission, the interdisciplinary team (IDT) evaluates the diabetic resident and implements a plan of care to ensure orders are received and are accurate related to blood glucose monitoring and antidiabetic agents. Blood glucose orders should include parameters to follow in communicating with the physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Antidiabetic agents (insulin or oral) are administered per physician order. III. Resident #4 A. Resident status Resident #4, age 78, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus, stage 5 chronic kidney disease (end stage), dependence on renal dialysis and acquired absence of right and left legs below the knee (amputations). The 10/9/24 minimum data set (MDS) assessment revealed Resident #4 was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10 out of 15. He required total assistance from staff for transfers, partial assistance with dressing and propelled himself in a wheelchair. The MDS assessment indicated Resident #4 received insulin injections seven days during the seven-day assessment review period. B. Record review Review of Resident #4's December 2024 CPO revealed the following physician's orders related to diabetes: Novolog (short acting insulin) 100 units/milliliter (ml), inject four units subcutaneously (under the skin) after meals. If the resident does not eat, hold the dose, ordered 1/29/24. Check blood glucose every morning and evening. If blood glucose is less than 100 milligram/deciliter (mg/dl) in the evening, do not administer the insulin. If blood glucose is less than 60 mg/dl, and the resident is able to swallow, give orange juice and re-check blood glucose every 15 minutes until within normal limits (WNL). If blood glucose is below 60 mg/dl and the resident is unable to swallow, give one milligram of glucagon intramuscularly (IM). Recheck blood glucose every 15 minutes until WNL and notify the provider, ordered 6/23/23. -The above physician's order to check the resident's blood glucose levels indicated if Resident #4's blood glucose level was below 100 mg/dl in the evening, the resident was not to receive insulin, however, the physician ordered parameter was not linked to the resident's Novolog insulin order. -Review of the December 2024 revealed there were no physician orders for what to do if the resident's blood glucose was too high (hyperglycemia). A review of the October 2024 and November 2024 medication administration records (MAR) revealed Resident #4 was administered Novolog insulin when the resident's blood glucose levels were below the physician ordered 100 mg/dl parameter in the evening on the following days: -On 10/29/24 Resident #4's evening blood glucose level was 94 mg/dl; -On 11/8/24 Resident #4's evening blood glucose level was 84 mg/dl; and, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/27/24 Resident #4's evening blood glucose level was 85 mg/dl. -According to the physician ordered parameters for Resident #4's Novolog insulin, the resident should not have received the insulin on 10/29/24, 11/8/24 and 11/27/24 when his blood glucose level was less than 100 mg/dl (see physician's order above). A review of the October 2024 MAR further revealed the following: -On 10/9/24 Resident #4's evening blood glucose was 107 mg/dl; and, -On 10/19/24 Resident #4's evening blood glucose was 142 mg/dl. -Resident #4's documented blood glucose level was above the physician ordered parameter for withholding the resident's Novolog insulin on 10/9/24 and 10/29/24, however, there was no documentation to indicate the resident had received the insulin or any documentation to indicate why the medication had not been given. IV. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 12/4/24 at 10:02 a.m. LPN #4 said if Resident #4's blood glucose level was below 100 mg/dl in the evening, she would hold the Novolog insulin and follow the hypoglycemia (low blood sugar) protocol if indicated. LPN #4 said if a blood glucose level reading was over 400 mg/dl she would call the physician. She said each resident should have a protocol for hyperglycemia or hypoglycemia in their physician's orders. -However, LPN #4's initials and a checkmark were documented on the October 2024 MAR the evening of 10/29/24, which indicated Resident #4's Novolog insulin was administered, even though the resident's blood glucose level reading was 94 mg/dl (below the physician ordered parameter to hold the insulin). LPN #4 said if there was a checkmark and initials on the MAR, it indicated the medication was administered. Registered nurse (RN) #1 was interviewed on 12/5/24 at 8:50 a.m. RN #1 said she normally held the Novolog insulin if Resident #4's blood glucose level was under 100 mg/dl in the evening or if he did not eat his meal. RN #1 said she was very diligent about his physician ordered parameters. -However, RN #1's initials and a checkmark were documented on the November 2024 MAR the evening of 11/27/24, which indicated Resident #4's Novolog insulin was administered, even though the resident's blood glucose level was 85 mg/dl (below the physician ordered parameter to hold the insulin). RN #1 said if the MAR was checked off on 11/27/24 that she administered the insulin, she must have administered it to Resident #4. The director of nursing (DON) was interviewed on 12/4/24 at 10:10 a.m. The DON said Resident #4's Novolog insulin order should have had the blood glucose parameter included in the physician's order for the medication. The DON said Resident #4 should not have received the Novolog insulin if his blood glucose level was under 100 mg/dl. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said Resident #4 should have had a hyperglycemic protocol in his physician orders. The DON was interviewed a second time on 12/4/24 at 10:33 a.m. The DON confirmed Resident #4's Novolog insulin was documented as administered on 10/29/24 11/8/24 and 11/27/24, when the resident's blood glucose was below the physician ordered parameter for holding the insulin. The DON said there was no documentation in the resident's medical record indicating the insulin was held. The DON said she would rewrite the physician's order to clarify when the insulin should be held, and add the parameter to hold the insulin if the blood glucose level was below 100 mg/dl within the Novolog insulin order. The DON said she would add a hyperglycemic protocol order to Resident #4's physician orders. The DON said the MAR should not have been left blank when a medication was scheduled to be administered. The DON was interviewed a third time on 12/5/24 at 11:04 a.m. The DON said the consulting pharmacist completed a monthly review of Resident #4's medications but did not provide any recommendations regarding the resident's insulin. The DON said the pharmacy consultant should be monitoring for missing documentation on the MARs and ensuring blood glucose parameters were followed. The DON said she would provide education to the nurses on following blood glucose parameters and documentation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50853 Based on observations, record review and interviews, the facility failed to ensure food was prepared, stored, and served under safe and sanitary conditions to prevent the potential contamination of food and the spread of food-borne illness in one of two dining rooms. Specifically, the facility failed to: -Ensure hand hygiene was performed appropriately while assisting residents with meals; and, -Ensure staff did not handle ready to eat food with bare hands. I. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 12/11/24 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. II. Facility policy and procedure The Feeding Assistance policy and procedure, dated 5/5/22, was provided by the nursing home administrator (NHA) on 12/5/24 at 11:53 a.m. It read in pertinent part, Wash hands before handling food. Gloves must be worn if raw food is being handled. When feeding residents, hand hygiene must be performed for at least 20 seconds between each resident that is being fed. Do not handle food with bare hands. Use utensils to offer food to residents. III. Observations During a continuous observation in the main dining room on 12/24/24m beginning at 11:52 a.m. and ending at 12:05 p.m., the following was observed: Certified nurse aide (CNA) #4 was assisting residents with lunch in the main dining room. While CNA #4 was assisting Resident #32, CNA #4 rubbed under his nose with his right hand, then picked up Resident #32's fork with the same hand and gave Resident #32 a bite of food. CNA #4 did not perform hand hygiene after touching his face. CNA #4 scratched his nose with his right hand, picked up Resident #32's fork and gave him another bite of food with the same hand. He did not perform hand hygiene after touching his nose. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #4 performed hand hygiene with alcohol based hand rub and assisted Resident #14, who was sitting at the same table. CNA #4 assembled Resident #14's hamburger. CNA #4 used his bare hands to handle the raw onion and bun. Without performing hand hygiene, CNA #4 picked up Resident #32's spoon and gave him another bite of food CNA #4 picked up a dinner roll with his bare hand and offered it to Resident #32, who took a bite. CNA #4 performed hand hygiene and handed Resident #14 his hamburger with his bare hand. CNA #4 then picked up the dinner roll for Resident #32 with his bare hand and gave him another bite of roll. CNA #4 did not perform hand hygiene between assisting different residents. -CNA #4 did not perform hand hygiene after touching his face or between assisting two residents and handled ready to eat food with his bare hands. On 12/3/24 at 11:46 a.m. CNA #4 was assisting Resident #32 with lunch. CNA #4 buttered Resident #32's cornbread, holding the bread with his bare hand. CNA #4 rubbed his hands on his scrub pants then picked up Resident #32's spoon and gave him a bite of food. -CNA #4 handled ready to eat food with his bare hands and did not perform hand hygiene after rubbing his hands on his scrub pants. At 11:52 a.m. an unidentified dietary aide served a hamburger and french fries to Resident #14. CNA #4 performed hand hygiene and put the top bun on the hamburger using his bare hands. CNA #4 then cut the hamburger in half, holding it with his bare hand and picked up half of the hamburger with his bare hand and offered it to Resident #14. -CNA #4 handled ready to eat food with his bare hands. III. Staff interviews The infection preventionist (IP) was interviewed on 12/4/24 at 9:00 a.m. The IP said when the staff assisted the residents in the dining room with eating, the staff should perform hand hygiene between each resident. The IP said, if the staff were assisting more than one resident they should perform hand hygiene in between residents. She said the staff should also perform hand hygiene after touching any dirty surface. The IP said the staff should pick up food with utensils, cut food with a fork and knife and not handle food with bare hands. The NHA was interviewed on 12/5/24 at 10:56 a.m. The NHA said the staff should use gloves or utensils to handle ready to eat food and should not touch it with bare hands. The NHA said this was important because their hands could be dirty and they could spread infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50853 Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to ensure appropriate hand hygiene was conducted while performing wound care. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Clinical Safety: Clean Hands for Healthcare Workers (2/27/24), retrieved on 12/10/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety, If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Always clean your hands after removing gloves. II. Facility policy and procedure The Hand Hygiene policy, dated 4/8/22, was provided by the nursing home administrator (NHA) on 12/5/24 at 11:53 a.m. It read in pertinent part, Our facility acknowledges that strict adherence to hand hygiene practices will significantly reduce the spread of infection. Hand hygiene will be performed to control infection, transfer of contaminants, and reduction of viable microorganisms. Perform hand hygiene before and after having direct contact with residents or their immediate environment, after contact with body fluid/excretions, mucous membranes, non-intact skin, wound dressings or resident equipment and after removing gloves. III. Observations On 12/4/24 at 2:08 p.m. licensed practical nurse (LPN) #5 was providing wound care for Resident #38's stage 2 pressure ulcer on her coccyx. LPN #5 prepared a clean field on the over bed table and placed the wound care supplies there. LPN #5 assisted Resident #38 to turn onto her side. She then removed the soiled dressing and cleansed the wound. LPN #5 removed her soiled gloves and donned (put on) clean gloves without performing hand hygiene. LPN #5 applied the treatment and clean dressing to the wound, removed her gloves and performed hand hygiene. -LPN #5 did not perform hand hygiene after removing soiled gloves and before donning clean gloves and handling clean wound dressings. IV. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #5 was interviewed on 12/4/24 at 2:15 p.m. LPN #5 said she should have performed hand hygiene after removing the dirty gloves and before putting on clean gloves and handling the clean dressing. Registered nurse (RN) #4 was interviewed on 12/4/24 at 3:00 p.m. RN #4 said she was the wound nurse and a nurse manager. RN #4 said she provided education recently to LPN #5 on performing hand hygiene when changing her gloves during wound care. RN #4 said hand hygiene should be performed after removing dirty gloves.