STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065220	A. Building B. Wing	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbine Manor Care Center	530 W 16th St Salida, CO 81201

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** II. Resident #47 A. Resident status Resident #47, age above 65, was admitted on [DATE]. According to the October 2023 CPO, the diagnoses included chronic atrial fibrillation and anxiety disorders. The 7/12/23 minimum data set (MDS) assessment revealed, the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She had no behaviors and did not reject care. All her activities of daily living only occurred once or twice. She used oxygen and received antidepressants daily. B. Record review The October 2023 CPO documented Resident #47 was ordered: -Lexapro (antidepressant) 15 mg (milligrams) by mouth one time a day for depression; -Cymbalta (antidepressant) 60 mg by mouth at bedtime for depression: and -Digoxin 125 mcg (micrograms) one time a day on Monday, Tuesday, Wednesday, Friday, Saturday, and Sunday. The digoxin was administered on 9/23/23. Her heart rate was 58. The digoxin was administered a second time on 9/27/23. Her heart rate was 57. There were no consents and black box warnings for the two antidepressants administered daily. Care Plans The antidepressant medication care plan, initiated 7/15/23. It documented the resident used the antidepressant medication for depression. The interventions included educating resident/family/caregivers about risks, benefits and the side effects and /or toxic symptoms. There was no care plan in place related to the use of digoxin. C. Staff interviews (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #1 was interviewed on 10/12/23 at 10:08 a.m. She said consents should be signed for antidepressants before administration of the medication. She said the consent consisted of potential side effects and special attention for a resident with heart disease. She said it was important for the consents to be signed so the resident/family would be aware of the risks of taking the medication. She said Digoxin should never be given if the resident's heart rate was below 60. She said it could cause low heart rate and Digoxin toxicity. The director of nursing (DON) was interviewed on 10/12/23 at 2:06 p.m. She said consents should be signed before administering an antidepressant. She said the resident/family should be aware of possible side effects and adverse reactions. She said Digoxin should not be given if a resident's heart rate was below 60. She said parameters should have been put into place to always check the resident's heart rate before administering Digoxin. She said if the heart rate was below 60 and the resident was given the medication, it could drop the heart rate even lower and cause an adverse event. The regional director of clinical services (RDCS) was interviewed on 10/12/23 at 3:59 p.m. She said the social worker was not aware that she was responsible for getting consents signed. She said the facility had completed an audit to make sure all consents for psychotropic medications were in place. Based on record review and staff interviews, the facility failed to ensure four (#44, #103, #203 and #47) of seven out of 28 sample residents were provided services that meet professional standards of quality. Specifically, the facility failed to: -Clarify physician's orders and obtain dose information prior to administration of topical skin medication for Residents #44, #103 and #203; -Hold Digoxin (to treat heart failure) when Resident #47's heart rate was below 60; and, -Ensure consents and black box warnings were in place for the use of antidepressants before administration for Resident #47. Findings include: I. Topical skin medication orders A. Professional reference The Voltaren (Diclofenac) gel drug information was accessed on 10/11/23 on the Physicians Drug Reference website at https://www.pdr.net/drug-summary/Voltaren-XR-diclofenac-sodium-2033. Diclofenac is a nonsteroidal anti-inflammatory (NSAID) medication that could be prescribed in intravenous, oral, topical, and ophthalmic formulations. The use of analgesic and antipyretic properties increases the risk of serious gastro-intestinal (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	events and may increase serious cardiovascular events; use the lowest dose of the shortest time. The topical dosage of diclofenac gel is prescribed as four grams (four and one half inches) topically four times a daily, with a maximum of 16 grams a day per lower extremity joint) and/or two grams (two and one fourth inches) topically four times daily per upper extremity joint. Do not exceed a total dose of 32 grams over all affected joints. B. Facility policy The Medication Administration policy, dated 8/24/23, was received by the nursing home administrator (NHA) on 10/16/23. The policy stated in pertinent part: Staff who are responsible for medication administration will adhere to the Rights of Medication Administration; Right dose. Check the medication administration record and the doctor's order before medication. Use standard measuring devices such as syringes, graduated cups, or scaled droppers. If there is any doubt about the dose on the medication administration, required considerations including the purpose, diagnosis or indication for use is required for administration of medication. A physician order that includes dosage, route, frequency, duration, and other record or if there is a question on the drug, stop and verify all information before administering. C. Record review Resident #44 had a physician order Voltaren gel one percent. The order directed the medication to be applied every 12 hours as needed for pain and failed to include a dose. The resident received the medication on 10/9/23 and 10/10/23. Resident #103 had a physician order for Diclofenac gel one percent. The order directed the medication to be applied every eight hours as needed for pain and failed to include a dose. The resident received the medication on 10/1/23, 10/2/23 and 10/3/23. Resident #203 had a physician order for Voltaren gel one percent. The order directed the medication to be applied every 12 hours as needed for pain and failed to include a dose. The resident received the medication on 10/10/23. D. Interviews Registered nurse (RN) #1 was interviewed on 10/11/23 at 3:03 p.m. She said she was aware Voltaren gel was a medication that required a measured dose. She said if a medication order was missing a dose the nurse should contact the physician to clarify the order. The RN said Voltaren gel was received packaged from the manufacturer with a dose guide for accurate measurement. The director of nursing (DON) was interviewed on 10/11/23 at 3:20 p.m. She said every medication order was expected to include a dose as prescribed by the physician. The DON said if a medication dose was missing the nurse was to contact the physician and clarify the medication order prior to medication administration. The DON said was she was unaware the three medication orders for Resident #44, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#103 and #203 were missing dose information. E. Facility follow-up On 10/11/23 at 3:55 p.m., the DON completed a record audit of physician's orders for Voltaren gel. She clarified physician's orders and obtained dose information for Volaren gel for Residents #44, #103 and #203.

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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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide services by qualified persons for one (#105) out of 10 residents reviewed for falls out of 28 sample residents. Specifically, the facility failed to ensure Resident #105 was assessed by a registered nurse (RN) after a fall. Findings include: I. Resident status Resident #105, age above 65, was admitted on [DATE] and discharged [DATE]. According to the April 2023 computerized physician orders (CPO), the diagnoses included vascular dementia, weakness, unsteadiness on feet, difficulty in walking, non-traumatic acute subdural hemorrhage (brain bleed), lack of coordination and muscle weakness. The 4/14/23 minimum data set (MDS) assessment revealed, the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of one out of 15. He had physical and verbal behavioral symptoms directed towards others as well as other behavioral symptoms not directed at others, which put the resident at significant risk for physical illness or injury. He wandered daily. He had a worsening in his behavior. He required extensive assistance with bed mobility, transfers and locomotion on and off the unit, dressing, eating, toilet use and personal hygiene. He used a wheelchair. The resident had two or more falls since admission with injury and one with major injury. II. Record review The fall care plan, initiated 11/23/22 and revised 5/1/23, documented the resident was at risk for falls related to a history of falls and dementia. The goal was for the resident not to sustain serious injury requiring hospitalization. According to a progress note dated 3/9/23 at 1:30 p.m. the housekeeping staff witnessed Resident #105 fall in his room and get himself up off of the floor. The note was written by a licensed practical nurse (LPN). According to a progress note dated 3/16/23 at 12:47 p.m. Resident #105 was found on the floor by ancillary staff near his bed. The resident's head and neck areas were intact. His grip strength was equal to both sides and his range of motion was within normal limits. The note was written by a LPN. According to a progress note dated 3/25/23 at 11:34 a.m. a certified nurse aide (CNA) witnessed Resident #105 fall in his room next to his bed. The resident's head and neck areas were assessed and intact. His grip strength was equal to both sides and his range of motion was within normal limits. The note was written by a LPN. According to a progress note dated 4/7/23 at 1:11 p.m. Resident #105's roommate witnessed him fall out of bed while trying to ambulate on his own. The note was written by a LPN. -The note did not include an assessment for injuries. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a progress note dated 4/16/23 at 12:24 a.m. the nurse was called to Resident #105's room and found him lying on the right side of the floor in the doorway to his room. The resident was noted to have a skin tear to his right forehead above his eyebrow, skin tear to his right hand second knuckle, and a skin tear to his right elbow. Neurological checks were initiated and upper and lower extremity strength were equal. The note was written by a LPN. According to a progress note dated 4/17/23 at 9:15 p.m. Resident #105 passed out and fell out of his wheelchair onto the lobby floor. Blood was noted in his catheter and vomit coming from his mouth. He had a skin tear to his left elbow. The note was written by a LPN. -A full review of the residents medical record was conducted on 10/11/23. The medical record did not reveal documentation of the resident being assessed by a RN after each of the above falls. III. Staff Interviews Certified nurse aide (CNA) #1 was interviewed on 10/12/23 at 10:01 a.m. She said if a resident had a fall, the CNA would report it to the nurse and start neurological checks on the resident. She said Resident #105 had many falls and was impulsive. RN #1 was interviewed on 10/12/23 at 10:08 a.m. She said an RN should assess a resident, no later than two hours, after a fall. She said after each fall, a resident should have interventions in place to prevent further falls. She said Resident #105 had many falls and interventions were put into place after every fall. She said she was not sure why an RN did not assess him for injury after each fall. The director of nursing (DON) was interviewed on 10/12/23 at 2:06 p.m. She said licensed practical nurses could not assess residents after a fall, because it was not in their scope of practice. She said a RN was required to assess a resident for injuries after a fall.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#17 and #47) of 10 residents who required respiratory care received the care consistent with professional standards of practice out of 28 sample residents. Specifically, the facility failed to: -Ensure a physician's order was in place for the use of oxygen for Resident #17; and, -Ensure Resident #17 and Resident #47 received oxygen therapy as ordered. Findings include: I. Facility policy The Oxygen Administration policy, last revised 8/2/21, was provided by the nursing home administrator (NHA) on 10/11/23 at 2:31 p.m. It read in pertinent part: Oxygen will be administered in accordance with physician orders and current standards of practice. All facility staff will be educated on oxygen administration, safety, and storage upon hire, annually, and as indicated thereafter. Oxygen administration helps relieve hypoxemia (low oxygen levels)and maintains adequate oxygenation of tissues and vital organs. Verify the practitioner's order for oxygen therapy because oxygen is considered a medication or therapy and requires a prescription. II. Resident #17 A. Resident status Resident #17, age above 65, was admitted on [DATE] and readmitted on [DATE]. According to the October 2023 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease (COPD), chronic atrial fibrillation (irregular heart beat), congestive heart failure, essential hypertension (high blood pressure) and dependence on supplemental oxygen. The 7/14/23 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) of 11 out of 15. He had no behaviors and did not reject. He required limited assistance with bed mobility, dressing, toilet use, and personal hygiene. Supervision with transfer and eating. He used oxygen. B. Observations Resident #17 was observed on 10/9/23 at 11:21 a.m. laying in bed wearing an oxygen nasal cannula. The oxygen concentrator flow rate was set at 3.5LPM (liters per minute). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17 was observed on 10/10/23 at 9:34 a.m. asleep in his wheelchair at the end of the hall. The portable oxygen flow rate was set at 4 LPM. Resident #17 was observed on 10/11/23 at 2:02 p.m. sleeping in bed. The oxygen concentrator flow rate was set at 3.5 LPM. Resident #17 was observed on 10/12/23 at 8:56 a.m. in the dining room eating breakfast.The portable oxygen flow rate was set at 4 LPM. C. Record review The resident's CPO was reviewed on 10/9/23 at 11:21 a.m. and revealed the resident did not have a physician's order for oxygen therapy. -A physician's order was obtained for the oxygen on 10/9/23 at 5:15 p.m. The order was for oxygen at 3 LPM continuously via nasal cannula. The Emphysema/COPD care plan initiated on 7/15/23 included oxygen as ordered. -The care plan failed to include the amount of oxygen to administer and the route (nasal cannula/mask. III. Resident #47 A. Resident status Resident #47, age above 65, was admitted on [DATE]. According to the October 2023 CPO, the diagnoses included COPD, tobacco use, chronic respiratory failure with hypoxia and dependence on supplemental oxygen. The 7/12/23 MDS assessment revealed, the resident was cognitively intact with a BIMS of 15 out of 15. She had no behaviors and did not reject care. All her activities of daily living only occurred once or twice. She used oxygen. B. Observations Resident #47 was observed on 10/9/23 at 9:35 a.m. laying in bed wearing an oxygen nasal cannula. The oxygen concentrator flow rate was set at 3.5 LPM. Resident #47 was observed on 10/10/23 at 9:29 a.m. sleeping in bed. The oxygen concentrator flow rate was set at 3.5 LPM. Resident #47 was observed on 10/12/23 at 8:55 a.m. sleeping in bed. The oxygen concentrator flow rate was set at 3.5 LPM. C. Record review A physician's order dated 8/29/23 revealed the resident was ordered oxygen at 2 LPM continuously per nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Emphysema/COPD care plan was initiated on 7/15/23. The interventions included oxygen as ordered. -The care plan failed to include the amount of oxygen to administer and the route (nasal cannual/mask). D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 10/12/23 at 10:01 a.m. The CNA said the nurses let the CNAs know how many liters of oxygen a resident was on. Registered nurse (RN) #1 was interviewed on 10/12/23 at 10:08 a.m. She said the nurse received oxygen orders from the physician to include the amount of oxygen to administer and the route. She said a physicians order should have been in place before Resident #17 was placed on oxygen on 7/15/23. She said the resident should have been at 4 LPM at all times. She said she was not sure why he was at 3.5 LPM. -However, the resident's oxygen order required 3LPM (see order above). She said Resident #47's oxygen should have been set at 2 LPM. She said she was not sure why it was set at 3.5LPM. She said too much oxygen was not good for residents with COPD since it could lead to oxygen toxicity very quickly. The director of nursing (DON) was interviewed on 10/12/23 at 2:06 p.m. She said a physician's order should be in place before administering oxygen to a resident since it was considered a medication. She said the nurse should have followed the physician's orders for the amount of oxygen to be administered. She said a resident with COPD could have negative effects on the brain and respiratory distress if given too much oxygen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and interviews, the facility failed to store, prepare and serve food in a sanitary manner. Specifically, the facility failed to: -Ensure potentially hazardous foods were monitored, held and cooled at appropriate temperatures; and, -Ensure dish room sanitation was maintained and dish room walls were a smooth cleanable surface. Findings include: I. Potentially hazardous foods monitored, held and cooled at appropriate temperatures A. Professional reference The Colorado Retail Food Regulations, effective 1/1/19, were retrieved 10/16/23 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, The person in charge shall ensure that: Employees are properly maintaining the temperatures of time and temperature control for safety foods during hot and cold holding through daily oversight of the employees' routine monitoring of food temperatures; employees are using proper methods to rapidly cool time/temperature control for safety foods that are not held hot or are not for consumption within four hours, through daily oversight of the employees' routine monitoring of food temperatures during cooling. Cooked time and temperature control for safety food shall be cooled within two hours from 135 degrees fahrenheit to 70 degrees fahrenheit and within a total of six hours from 135 degrees fahrenheit to 41 degrees fahrenheit or less. Except during preparation, cooking, or cooling, time and temperature control for safety food shall be maintained at 135 degrees fahrenheit or above, or at 41 degrees fahrenheit or less. Time and temperature control for safety food includes cut leafy greens. B. Facility policy and procedure The Keeping Hot Food Hot and Cold Food Cold inservice, undated, was provided by the nursing home administrator (NHA) on 10/12/23 at 10:28 a.m. It revealed in pertinent part, Not only is it important for us to keep food safe during delivery, storage and preparation but we must also ensure that standard practices are followed during the holding of hot and cold food items. Bacteria grow at a much higher rate at room temperature. Therefore, we should keep hot food hot and cold food cold. Ensure that cold items placed in the dining rooms but not immediately served to the residents are held at 40 degrees fahrenheit or lower. C. Observations and record review On 10/11/23 at 11:02 a.m. the following items were observed in the walk-in refrigerator: -A full size two inch deep steam table pan on the bottom shelf of the walk in refrigerator. The pan was covered with aluminum foil and written on the foil in black marker was pot roast for lunch (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/10/23. -A six inch deep third size steam table pan with cooked sausage patties in liquid and covered with clear plastic wrap. The date 10/11/23 was written with black marker on the plastic wrap covering the pan. -A six inch deep sixth size steam table pan was observed with cooked, ground sausage and covered with clear plastic wrap. The date 10/11/23 was written with black marker on the plastic wrap covering the pan. On 10/11/23 at the following observations were made during lunch service in the dining room: -At 11:44 a.m. three full size baking sheet pans containing individually sliced and plated lemon meringue pies were on a baking rack in the dining room. Throughout service, the individually sliced pie pieces were held at room temperature and served to residents in the dining room or covered with foil and placed on resident room trays to be delivered. -At 11:45 a.m. battered fish was placed in the hot food holding steam table. [NAME] (CK) #1 took the internal temperature of the battered fish and the temperature was 162 degrees fahrenheit. -At 12:35 p.m. CK #1 lifted the top lid on half size deli refrigerator, reached into the pan of sliced lettuce and placed the sliced lettuce on a hamburger. The hamburger was then served to a resident. -At 12:38 p.m. a full size baking sheet pan of individually sliced and plated lemon meringue pies was still on the baking rack in the dining room. Room tray carts for two resident halls remained in the dining room with a total of 13 room trays not yet assembled including dessert. -At 12:46 p.m. eight pieces of battered fish were still in the hot holding steam table. A digital food thermometer was inserted into two different pieces of the battered fish and the internal temperature of the fish was 124 and 127 degrees fahrenheit. CK #1 said she would put a lid on top of the battered fish, and placed a metal lid over the pan that contained the battered fish. CK #1 then continued to serve resident meals. -At 12:57 p.m. a slice of lemon meringue pie was removed from the baking rack. A digital food thermometer was inserted into the piece of lemon meringue pie and the temperature was 50.6 degrees fahrenheit. The pie was placed on a test tray, and at 1:07 p.m. the temperature of the same piece of pie was 54 degrees fahrenheit. On 10/11/23 at 2:29 p.m. the box of lemon meringue pie revealed the lemon meringue pie was made with egg white, a time and temperature controlled for safety ingredient. The label on the lemon meringue pie container revealed the pie was to be stored frozen, served chilled, and not held at room temperature. -The lemon meringue pie served at lunch on 10/11/23 was held at room temperature for the duration of lunch service, the temperature of the pie was not monitored during service and the pie served reached a temperature above 40 degrees fahrenheit. -The temperature of the cut lettuce served at lunch was not monitored before or after lunch (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	service. The temperature of the fish dropped below 135 degrees fahrenheit, the temperature of the fish was not monitored or held at the appropriate hot temperature. D. Record review Food temperature logs dated 8/28/23 to 10/12/23 were reviewed on 10/12/23. The food temperature log documented, Cold foods should be at 40 degrees fahrenheit or below and hot foods should be at 140 to 170 degrees fahrenheit. Temperatures are recorded before food is served. If food temperatures are not within these ranges, corrective action must be taken before food is served to residents. Record the temperature of all hot and cold foods. -Food temperature cooling logs were requested but were not provided. Cooling temperature logs were not used to monitor and record cooling temperatures and times for the roast beef, sausage patties and ground sausage in the walk in refrigerator. -The initial temperature of the lemon meringue pie and sliced lettuce served on 10/11/23 was not recorded on the temperature log. The temperature log did not have a column for recording temperatures of food at the end of the meal to verify foods were held correctly. E. Staff interviews CK #1 was interviewed on 10/11/23 at 12:05 p.m. CK #1 said she had not taken the temperature of the lemon meringue pie. She said the dietary staff removed the cold food out of the walk in refrigerator and took the temperature of foods served at the end of meal service but did not write the temperatures down. CK #1 was interviewed on 10/11/23 at 1:00 p.m. CK #1 said if the hot holding temperatures were too cold on food held in the steam table she would ask for more food to be cooked in the kitchen and brought to her. She would then serve the hot food instead of the food that was below the correct temperature. CK #1 said she did not know the temperature of the sliced lettuce had to be monitored. CK #1 and CK #2 were interviewed on 10/11/12 at 2:20 p.m. CK #1 and CK #2 said to cool the cooked food, the food was set on the table in the kitchen while other tasks were completed. CK #1 and CK #2 said the time and temperature of the leftover cooked foods was not monitored or recorded on a log before putting the leftover food in the walk in refrigerator. CK #1 and CK #2 said they did not know the temperatures of potentially hazardous cooked foods had to be monitored. CK #1 said she used the leftover sausage from breakfast to make ground sausage for the next breakfast meal for residents on mechanical soft diets. The nutrition services manager (NSD) was interviewed on 10/12/23 at 10:00 a.m. The NSD said the dietary staff have to monitor food holding temperatures. He said staff made him aware if food in the steam table was not at the correct holding temperature during meal service and the dietary staff made new food quickly. The NSD said he did not think the dietary staff took a beginning and end food temperature at every meal and he did not think the staff knew monitoring holding temperatures was required. The NSD said the dietary department did not reuse and reheat a lot of food leftover food. -However, the facility did have leftovers (see observations above). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	II. Dish room cleanliness and maintenance A. Professional reference The Colorado Retail Food Regulations, effective 1/1/19, were retrieved 10/16/23 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Nonfood-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling or that require frequent cleaning shall be constructed of a corrosion-resistant, nonabsorbent, and smooth material. Materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: smooth, durable, and easily cleanable for areas where food establishment operations are conducted and nonabsorbent for areas subject to moisture such as food preparation areas, walk-in refrigerators, warewashing areas, toilet rooms, mobile food establishment servicing areas, and areas subject to flushing or spray cleaning methods. Floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. Walls and ceilings that are of smooth construction, nonabsorbent, and in good repair can be easily and effectively cleaned. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude (prevent) accumulation of soil residues. B. Observations On 10/9/23 at 9:25 a.m. the dish room was observed. Multiple dried food spots and debris were on the wall tile under the dish machine table. Dried food splatters were on the ledge of the dish machine table. The corner of the floor in the dish room had sticky black build up. The dish room entrance and walls inside the dish room consisted of ceramic tile, with multiple tiles missing from the wall inside the dish room and at the entrance to the dish room. Four coving (curved tile at the wall and floor juncture) tiles were missing under the dish machine table. A piece of fiberglass reinforced polymer wall section was placed in front of a section of wall tile under the dish machine. The fiberglass reinforced polymer wall section was not flush with the tile, but covered some of the tiles and the bottom and side edges of the fiberglass reinforced polymer wall section were not sealed. On 10/11/23 at 11:11 a.m. the dish room was observed. Multiple dried food spots and debris were on the wall tile under the dish machine table. Dried food splatters were on the ledge of the dish machine table. The corner of the floor in the dish room had sticky black build up. Four tiles were missing from the wall inside the dish room next to the dish machine leaving the wall underneath exposed that was porous with small holes. Eight tiles were missing from the wall to the dish room entrance leaving the material behind the tiles exposed with what appeared to be dried glue or adhesive. Four coving (curved tile at the wall and floor juncture) tiles were missing under the dish machine table. One piece of coving tile was leaning against another coving tile instead of being sealed to the wall. A piece of fiberglass reinforced polymer wall section was placed in front of a section of wall tile under the dish machine. The fiberglass reinforced polymer wall section was not flush with the tile, but covered some of the tiles and the bottom and side edges of the fiberglass reinforced polymer wall section were not sealed. The bottom of the fiberglass reinforced polymer wall section was in front of the coving tile instead of flush with the top edge the coving tile and sealed. C. Record review The Daily Nutrition Services Cleaning Schedule was provided by the NSD on 10/12/23 at 10:30 a.m. The cleaning scheduled included to wipe down dish room counters but did not include to wipe down the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dish room walls. D. Staff interviews The registered dietitian (RD) was interviewed on 10/11/23 at 11:15 a.m. She said the dish room was going to be remodeled. The environmental services director (ES) was interviewed on 10/11/23 at 1:15 p.m. The ES said he had reached out locally to get some vendors to fix the dish room tile and floor and possibly fix the grout in the dish room floor but had difficulty getting a return call from the vendors. He said he did not have any quotes yet for the items that needed repair in the dish room. The NSD was interviewed on 10/12/23 at 10:00 a.m. He said the corporate vice president (CVP) called a vendor who was scheduled to come the following week to the facility and fix the tiles in the dish room. The NSD said the cleaning task for the dish room was on the evening dishwashing position task sheet and/or the staff working the position knew what they should be doing. The NSD said he was unsure why the dish room cleaning was not being completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Specifically, the facility failed to: -Ensure the facility had a way to test water for the growth of Legionella by using expired Legionella test kits; -Ensure staff properly disposed of personal protective equipment (PPE) when the facility had an outbreak of COVID-19; and, -Ensure staff properly maintained respiratory supplies by failing to change oxygen cannulas weekly for two residents when the facility had an outbreak of COVID-19. Cross-reference F882 infection preventionist qualifications Findings include: I. Facility policy The Infection Prevention and Control program and plan, dated [DATE], was received [DATE] by the infection preventionist (IP) and read in pertinent part, The facility has an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infection to the extent possible. The facility has systems for the prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff, and visitors. This system includes an ongoing system of surveillance designed to identify possible communicable diseases and infections before they can spread to other persons in the facility and procedures for reporting possible incidents of communicable disease or infections. General procedures. Assign one or more individuals with training in infection control to provide on-site management of the infection control program. The facility administration and infection preventionist should ensure that current infections control standards of practice are based on recognized guidelines and facility assessment. The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring, and/or reporting of infections, communicable disease and outbreaks. The program includes early detections, management of a potentially infections, symptomatic resident that requires laboratory testing and/or the implementation of appropriate personal protective equipment (PPE). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff follow the infection control plan standards, policies, and procedures (appropriate use of PPE). II. Water testing failure A. Manufacturer package insert information The manufacture website for Lovibond water testing kits was accessed on [DATE] at https://www.lovibond.com/usa-en/water-testing/support-service/download-center. The manufacture package insert read, test kits expired 18 months from the date of manufacture and all test kits were marked with a printed expiry date. B. Facility plan The Water Management Plan, dated [DATE], was received on [DATE] by the nursing home administrator (NHA). -The plan failed to include a schedule to test the facility water for Legionella. C. Record review On [DATE] the environmental services director (ESD) provided copies of Legionella testing he completed on [DATE], [DATE] and [DATE], which showed the facility water was negative for Legionella. -However, the test kits used were Lovibond rapid test for Legionella pneumonia and were marked with expiration date of [DATE]. C. Staff interviews The ESD was interviewed on [DATE] at 12:10 p.m. He said the Legionella test kits had expired on [DATE]. He said he was unaware he used an expired test kit and an expired test kit could lead to an inaccurate test result. The ESD was unable to locate an unexpired test kit on [DATE] to complete an immediate water test for Legionella. The NHA was interviewed on [DATE] at 12:25. He said he was unaware water testing was completed with expired test kits. He said testing for Legionella in the facility water supply was necessary so that the facility could intervene to prevent illness. D. Facility follow-up On [DATE] at 3:15 p.m., the ESD said he ordered new testing kits for Legionella and will complete testing when the kits were delivered. II. PPE disposal failure A. Professional reference The Center for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated [DATE], (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	retrieved on [DATE] from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#r2 read in pertinent part, HCP (health care provider) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (goggles or a face shield that covers the front and sides of the face). Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. B. Observation On [DATE] at 11:45 a.m. a lunch tray for the resident in the room was placed on the top of the PPE set of drawers and the top drawer with clean PPE supplies was left opened. A used PPE gown was draped across the top of the set of drawers and had direct contact with the resident's lunch tray, items on the tray, the top surfaces of the drawers and the clean PPE items inside the opened top drawer. C. Staff interviews The director of nurses (DON) was interviewed on [DATE] at 11:49 a.m. She observed the used PPE gown draped across the clean surfaces and said the used PPE should be placed in a trash bin designated for used PPE and not placed on top of the clean PPE distribution area. Certified nurse aide (CNA) #3 was interviewed on [DATE] at 11:57 a.m. She said she had the PPE gown on and was prepared to enter the resident's room but was interrupted. She said she removed the gown and placed it on the PPE set of drawers. She said since she had not entered the resident's room, the gown was clean. The CNA said that she had worked on the hallway and had provided care for other residents and said her dirty clothing contaminated the PPE gown. The CNA said she had received education and training from the infectionist preventionist (IP) but had not seen the IP for several weeks. III. Respiratory equipment A. Facility policy The Oxygen Administration/Safety/Storage/Maintenance policy, dated [DATE], was received by the NHA on [DATE]. The policy read in pertinent part, Infection Control: change oxygen supplies weekly and when visibly soiled. Equipment should be dated when setup or changed out. B. Observation On [DATE] at 11:27 a.m., the nasal cannula oxygen tubing for two residents (#40 and # 8) was observed labeled [DATE]. Both oxygen concentrators had a plastic zip lock bag taped to the concentrator to hold the cannula when not in use. Each bag was labeled [DATE]. C. Staff interviews CNA #2 was interviewed on [DATE] at 11:39 a.m. He said the facility policy was for the CNA to change oxygen cannulas and tubing every Sunday. He said a new oxygen tubing should be labeled with the date the equipment was provided to the resident. The CNA said the date was used to verify equipment was changed. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and interview, the facility failed to designate an interim infection preventionist (IP) that completed specialized training in infection prevention and control. Specifically, the full-time IP was on leave from the facility from 9/13/23 to 9/29/23 and 10/4/23 to 10/9/23. On 9/13/23 a resident tested positive for COVID-19, which led to a facility outbreak of COVID-19. From 9/13/23 to 10/2/23, twenty residents tested positive for COVID-19. The interim IP had not completed the education and training requirement prior to assuming the duties of the position. Findings include: I. Facility policy The Infection Prevention policy, dated 5/19/23, was received by the IP on 10/11/23 at 10:23 a.m. The policy documented in pertinent part, Our facility has an infection prevention and control program to prevent, recognize, and control the onset and spread of infection to the extent possible. The facility has systems for the prevention, identification, reporting, investigation and control of infection and communicable diseases of residents, staff, and visitors. The system includes an ongoing system of surveillance designed to identify possible communicable diseases and infections before they can spread to other persons in the facility and procedures for reporting possible incidents of communicable disease or infections. General procedures. Assign one or more individuals with training in infection control to provide on-site management of the infection control program. The individual designated will meet the qualification requirements outlined in F882. II. Record review On 10/11/23 the full-time IP provided documentation she completed specialized training for infection prevention on 3/19/23 and she was hired 2/23 as the facility ' s IP. -However, the IP was on 9/13/23 to 9/29/23 and 10/4/23 to 10/9/23 during the time there was a COVID-19 outbreak. The director of nursing (DON), who was interim infection preventionist, was unable to provide documentation she completed specialized training for infection prevention. Cross-reference F880 for failures with infection control. III. Interviews The IP and DON were interviewed together on 10/11/23 at 10:23 a.m. The IP said she received her IP (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	certificate for completed training on 3/19/23 and was a registered nurse. She said she worked full-time in the facility except for the dates of her leave. The IP said requirements for IP included primary professional training in nursing, work at least part-time for the facility and have completed specialized training in infection prevention and control. The DON said when the full-time IP was on leave, she was assigned to work as the interim IP. The DON had completed some classes on infection prevention but had not met requirements to obtain an IP certificate.