STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065129	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Shore Health & Rehab Facility	1365 W 29th St Loveland, CO 80538

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, record review and interviews, the facility failed to assess, accurately document and provide treatment for one (#32) of four residents reviewed for pressure ulcers out of 31 sample residents. Specifically, the facility failed to: -Ensure the progress of Resident #32's pressure ulcers was documented consistently and accurately; -Identify Resident #32 had a pressure wound which had reopened on her coccyx; and, -Obtain appropriate physician's orders for wound care treatment for Resident #32's reopened coccyx pressure ulcer. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved on 5/23/24 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Resident #32 Resident status Resident #32, age greater than 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included dementia, chronic kidney disease Stage II (mild), type II diabetes and a history of a right buttock stage 3 pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/5/24 minimum data set (MDS) assessment revealed the resident had a brief interview for mental status (BIMS) score of three out of 15. She was dependent on help for bed mobility, transfers, and showering, and required maximal assistance with toileting. The assessment indicated Resident #32 was at risk for developing pressure ulcers. She had two unhealed stage 2 pressure ulcers and one unhealed stage 3 pressure ulcers and no unstageable pressure ulcers. The assessment indicated the resident was not on a turning/repositioning program, had no nutritional interventions to manage skin problems and had no diabetic foot ulcers. B. Observations On 5/13/24, the following observations were made: At 12:30 p.m. the resident was observed sitting in her wheelchair and eating in the main dining room. At 1:03 p.m. the resident was observed sitting in her wheelchair across from the nurses' station. At 1:25 p.m. the resident was asleep and sitting in her wheelchair, still across from the nurses' station. At 1:44 p.m. staff was observed bringing the sit-to-stand machine out of the resident's room. The resident was on her back, asleep on a low air loss mattress (a specialty mattress designed to relieve pressure). On 5/14/24, the following observations were made: At 11:41 a.m. Resident #32 was in the dining room sitting in her wheelchair. At 12:08 p.m. the resident was still sitting in her wheelchair in the dining room. At 12:24 p.m. the resident was sitting in her wheelchair by the nurses' station. At 12:34 p.m. the resident's family wheeled her to her room. On 5/15/24 at 9:23 a.m. Resident #32 was observed during incontinence care. A wound about the size of a nickel was observed on the left of the resident's coccyx area. The wound was open and pink. The resident screamed in pain when staff wiped her bottom and put cream on the wound. She yelled, oh my god it hurts! C. Record review A Braden Scale assessment (a tool used for determining pressure ulcer risk) dated 1/8/24 revealed Resident #1 was at mild risk for developing pressure ulcers. -There were no additional Braden Scale assessments documented following the 1/8/24 assessment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The May 2024 CPO included the following physician's order: Barrier cream to sacrum and peri-areas with brief changes, ordered 1/10/24. -The order failed to reveal that the barrier cream was for treatment or protection of the resident's wound. On 3/29/24, the following wounds were documented At 9:15 a.m. the wound care physician (WCP) documented a resolved stage 3 pressure ulcer on the left buttock, and a Kennedy terminal ulcer on the left buttock with dimensions 0.3 centimeters (cm) by 0.3 cm by 0.2 cm. (A Kennedy terminal ulcer is a wound that can develop in people who are terminally ill or nearing the end of their life. It is a type of pressure ulcer that is characterized by its sudden onset and rapid progression). -No coccyx wound was noted. At 1:55 p.m., an NP/MD documented an evaluation of Resident #32's sacral wounds. The provider documented the resident had three small ulcers, two on the left gluteal cleft region and one on the right (the groove in between the left and right buttocks). The wounds were below the coccyx. The one on the right was a stage 2 that measured 0.3 cm by 0.3 cm. The one on the left was 0.2 cm by 0.4 cm and was consistent with a resolving stage 3. The third was 0.3 cm by 0.4 cm. The wounds were consistent with pressure ulcers and not skin failure and so it was the provider's opinion that the wounds should not be classified as Kennedy ulcers. At 2:36 p.m., a nursing staff member documented a stage 2 pressure wound on the right buttock with an onset date of 3/29/24 and dimensions of 0.3 c.m. by 0.3 c.m. by 0.1 c.m. At 2:50 p.m., a nursing staff member documented a stage 2 pressure wound on the coccyx with an onset date of 3/25/24 and dimensions of 0.5 cm by 0.5 cm by 0.1 cm. -The documentation, including the stage of wound, location and measurements of the wounds, from the WCP and the facility nursing staff did not match. At 2:54 p.m. a nursing staff member documented the resident had a stage 3 pressure wound on the left buttocks with moderate serosanguinous drainage, present since 12/10/24. The wound was cleansed, measured, and a new dressing applied. -The nursing staff member inaccurately documented the date as 12/10/24 instead of 12/10/23. On 4/4/24 at 2:28 p.m. the WCP documented a stage 3 pressure ulcer on the left buttock with dimensions of 1.2 cm by 0.4 cm by 0.2 cm had moderate serosanguinous drainage (a combination of blood, and clear, straw-colored liquid), but was stable. On 4/9/24 at 7:35 p.m., nursing staff documented the resident had no new skin concerns. -The nursing note did not indicate if the previously mentioned pressure wounds were still present. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/24 at 4:01 p.m. the WCP documented a resolved stage 3 pressure ulcer on the left buttock with prior dimensions of 1.2 cm by 0.4 cm by 0.2 cm and a stage 2 pressure ulcer on the coccyx with dimensions of 0.5 cm by 0.5 cm by 0.2 cm and prior dimensions of 1 cm by 0.5 cm by 0.2 cm. The care plan, revised 4/12/24, documented Resident #32 was to have a gel cushion to her wheelchair, have a low air loss mattress and offload (lay down) between meals. On 4/16/24 at 10:51 p.m. the weekly skin assessment documented the resident had no new skin concerns. On 4/19/24 at 9:01 a.m. the WCP documented a resolved stage 2 pressure ulcer stage on the coccyx. The care plan, revised 4/19/24, identified the resident had the following resolved wounds: -Stage 3 pressure wound on left buttocks - resolved 4/11/24; -Stage 2 pressure wound on coccyx - resolved 4/19/24; and, -Stage 2 pressure wound on right buttocks- resolved 4/3/24. On 4/23/24 at 7:17 a.m. the nursing skin assessment documented the resident had no new skin concerns. On 4/25/24 at 9:33 a.m. the food and nutrition progress note documented the resident had a stage 3 pressure injury on the right buttock. -However, according to the care plan revised 4/19/24, Resident #32's pressure wounds were all resolved as of 4/19/24. The care plan, revised 4/28/24, documented a dietary supplement was to be provided as ordered for wound prevention and healing and staff was to use a barrier cream for Resident #32 as prescribed. -The care plan did not specify where the barrier cream was to be applied. On 5/7/24 at 9:51 a.m. the nursing skin assessment documented the resident had no new skin concerns. On 5/7/24 at 8:28 p.m. RN #5, who was a hospice nurse documented that the resident's skin was intact. On 5/13/24 at 10:50 a.m., RN #6, who was a hospice nurse documented Resident #32 had erythema (redness) of the peri area (private area). On 5/14/24 at 10:58 p.m., a nursing note documented Resident #32 had a new skin concern. The new skin concern was a bruise on the back of the resident's right hand due to hitting the table in the dining room. -The skin assessment did not document any new wounds as skin concerns. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation to indicate the facility had identified that Resident #32's wound on her coccyx had reopened and that a physician had been notified (see observations above). D. Staff interviews The wound care nurse (WCN) was interviewed on 5/14/24 at 1:05 p.m. The WCN said she mostly cared for pressure, diabetic and vascular (arterial, venous, diabetic) wounds and sometimes skin tears. She said she typically monitored closed wounds, but once they opened up, she said she got the wound care physician (WCP) involved. She said Braden Scale assessments were completed on admission, quarterly and upon any change in condition. She said wounds were not typically measured upon admission, and there usually were not orders for barrier cream because barrier cream was a standard of care for incontinence. The WCN said Resident #32 had two stage 2 pressure wounds that were resolving. The WCN was interviewed again on 5/14/24 at 1:26 p.m. The WCN said the resident had no pressure injuries. The WCN said the resident previously had two pressure wounds, however, she said they were resolved. -However, the WCN said in her interview at 1:05 p.m. that Resident #32 had two stage 2 pressure wounds that were resolving. On 5/15/24 at 9:29 a.m., RN #1 said the wound on Resident #32's coccyx had been present for some time. She said it would heal and open up again repeatedly. She said the wound used to have a dressing but the resident was incontinent of bowel and they had to change the dressing multiple times throughout the day. She said removing dressings frequently was not good for the skin. RN #1 said the barrier cream seemed to work just as well as a dressing. She said the wound team was following Resident #32 and decided the cream was better than a dressing. She said the wound team was not following her anymore because her wounds were healed, and the staff just used zinc barrier cream on the wound. She said the staff had been using the cream without a dressing for at least a month. -However, Resident #32 was observed to have an open wound to her coccyx on 5/15/24 (see observations above). Nurse practitioner (NP) #1 was interviewed on 5/16/24 at 9:14 a.m. NP #1 said she was not notified that Resident #32 had an open wound on her coccyx or that staff were just using barrier cream to treat it. The director of nursing (DON) was interviewed on 5/16/24 at 11:44 a.m. The DON said she believed the coccyx wound was a fragile area. She said for wounds that were shallow, they could potentially be treated with zinc barrier cream, especially if the resident was incontinent. She said the physician should be contacted when there was a new wound or a reopened wound. E. Facility follow-up On 5/17/24 at 5:34 p.m. (after the survey exit) the facility submitted the following documentation: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Interdisciplinary team (IDT) note, dated 5/16/24 at 3:43 p.m. (during the survey) which documented Resident #32 had an open area on the left buttock. Zinc barrier cream was to be applied with each check and change and an order to monitor until resolved was entered.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, record review and interviews, the facility failed to ensure two (#32 and #1) of five residents reviewed for pain management out of 31 sample residents received timely, adequate pain control. Specifically, the facility failed to: -Ensure pain was effectively managed during incontinence care for Resident #32; -Ensure Resident #32 was provided as needed (PRN) pain medication prior to brief changes per physician's orders; -Ensure staff consistently documented Resident #32's pain levels every shift; and, -Ensure individualized non-pharmacological interventions were documented for Resident #32 and Resident #1. Findings include: Facility Policy The Pain Management policy, revised on 5/3/23, was provided by the director of nursing (DON) on 5/17/24 at 5:36 p.m. It read in pertinent part: Pain is subjective and is what the resident says it is, existing when and where the resident says it does. All residents will be evaluated for pain by utilizing a pain evaluation tool in the electronic medical record (EMR). The pain evaluation will be completed upon admission, readmission, quarterly, and with any significant change in condition. The pain evaluation includes the following: location(s), quality, intensity, associated symptoms, precipitating, aggravating and relieving factors, chronology, pattern (frequency, onset and duration of pain), medication regimen and other treatment modalities used for pain management and their degree of effectiveness. All subsequent pain evaluations will be documented on the Pain Evaluation in the EMR and/or the MAR (medication administration record) as applicable to include location, intensity rating, and response to pain management interventions. When a resident complains of pain, ask the resident to rate the level of pain using the numerical Scale using a pain level of zero (none) to ten (severe). Cognitively impaired residents or residents unable to respond verbally may not be able to rate their pain using a numeric scale. Non-verbal indicators of pain include: increased agitation, crying, grimacing, holding the area where the pain is located, calling out, decreased appetite, and any other behaviors which are unusual for the resident. Cognitively impaired residents have pain evaluated using the PAINAD (Pain Assessment in Advanced Dementia) Scale. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Around the clock (ATC) dosing for continuous pain, whether it be chronic or acute, is the key to effective pain management. Intermittent pain can be managed with intermittent (PRN) analgesic administration. (Every shift pain checks on the MAR should be completed after the resident receives the routine medication.) Do not forget the non pharmacological interventions such as repositioning, relaxation, aromatherapy, visualization, desensitization, massage, and humor therapy etc. Non-pharmacological interventions should be documented in progress notes and included on the individual resident care plan. II. Resident #32 Resident status Resident #32, age greater than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dementia, chronic kidney disease, type two diabetes and a history of a right buttock stage 3 pressure injury. The 4/5/24 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. She was dependent on two staff members for assistance with bed mobility, transfers and showering. She required maximal assistance of two staff members with toileting. B. Resident observations and interview On 5/13/24 at 10:36 a.m. moaning and yelling was heard from behind the closed door to Resident #32's room. At 10:42 a.m. certified nurse aide (CNA) #5 exited the room. CNA #5 said the resident was in a lot of pain during the transfer. She said the resident was in such pain that she did not feel comfortable proceeding with incontinence care and was on the way to inform the nurse about the pain. She said it was her first encounter with the resident as the resident was recently admitted to hospice care. At 10:44 a.m. registered nurse (RN) #1 entered the resident's room where the Resident #32 was lying in bed. RN #1 touched the resident's right foot and heel and the resident cried out in pain. RN #1 left the room and returned to give the resident pain medication. -RN #1 did not ask the resident where her pain was or what her level of pain was. On 5/15/24 Resident #32 was observed during a continuous observation, beginning at 9:03 a.m. and ending at 9:40 a.m. The following observations were made: At 9:08 a.m., Resident #32 was moaning while she waited for CNA #1 to return to help her transfer to bed. The resident said her whole right leg hurt. The resident was unable to describe her pain further or give a pain level for the right leg pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:23 a.m., after the resident was transferred to bed by RN #1 and CNA #1, RN#1 told CNA #1 the resident's brief should be changed. RN #1 told Resident #32 she needed to change her brief and started taking the resident's pants down. The resident started yelling No and hit RN #1 several times. The resident continuously yelled out, No while RN #1 and CNA #1 moved and changed her. Resident #32 yelled oh my god it hurts and hit RN #1 several times on her back. RN #1 asked the resident what hurt but the resident did not answer. The resident was breathing heavily and grimacing. During the incontinence care, an open wound was observed on the resident's left buttock. Resident #32 screamed in pain when the staff was wiping and putting cream on the wound. After incontinence care was completed, Resident #32 was positioned on her back, she stopped yelling and fell asleep. Resident #32 was hyperventilating, moaning loudly, groaning, crying, showed facial grimacing and was pulling and pushing away from the staff during the incontinence care. She was only able to be momentarily distracted by reassurances from RN#1 and CNA #1. C. Record review The care plan for pain, initiated 7/21/23 and revised 5/7/24, identified the resident had the potential for pain related to a wound and a history of a fracture. Pertinent interventions included the following: -Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition; -Monitor/document for probable cause of each pain episode. Remove/limit causes where possible; -Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting, dizziness and falls. Report occurrences to the physician; -Monitor/record pain characteristics: including quality (sharp, burning), severity (1 to 10 pain scale) anatomical location, onset duration (continuous, intermittent) aggravating factors and relieving factors; -Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain; -Observe resident closely for signs of pain, administer pain medications as ordered, and notify hospice nurse timely if there is breakthrough or uncontrolled pain; and, -Offer non-pharmacological interventions for pain prior to administering medication and PRN (as needed). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the care plan did not document what individualized non-pharmacological interventions were effective for Resident #32. The May 2024 CPO included the following physician's orders: Monitor pain every shift using the PAINAD scale, ordered 3/29/24. Tramadol HCl oral tablet (medication used to treat pain) 50 milligrams (mg), give 50 mg orally two times a day for pain, ordered 4/16/24. Acetaminophen (analgesic) 325 mg, give two tablets by mouth four times a day for pain, ordered 6/22/23. Tramadol HCl oral tablet 50 mg, give 50 mg orally for pain level of 6-10 on a pain scale of 1-10 twice daily as needed (PRN) before wound care and brief changes, ordered 4/19/24. Review of Resident #32's medication administration record (MAR) and treatment administration record (TAR) from 5/1/24 through 5/14/24 revealed Resident #32 received 13 out of 14 doses of scheduled, with one refusal. She received 52 out of 60 doses of scheduled acetaminophen, with three refusals and the resident was documented as sleeping for five administrations. -Resident #32 did not receive any doses of PRN Tramadol from 5/1/24 through 5/14/24, despite the resident having a physician's order to administer PRN Tramadol prior to wound care and brief changes. -The required monitoring of Resident #32's pain every shift was documented as completed on the TAR, however, the documentation did not include a pain score or description of the pain. -A pain score was documented six times in the first 14 days of May and was noted to be zero out of 10 for each. -No pain score was documented on 5/13/24, after the resident was observed yelling in pain and was given pain medication. A nursing pain evaluation, dated 4/12/24 at 10:38 a.m. by RN #1, revealed the resident had a chronic wound to the coccyx that contributed to pain. The resident was unable to describe what the pain felt like but additional symptoms associated with pain included decreased appetite, non-verbal signs including facial grimacing and moaning and verbal indications. The evaluation documented the resident's preferred pain scale was PAINAD but she was unable to state her acceptable level of pain. Measures that helped relieve pain were medication and relaxation. A progress note, documented on 3/17/24 at 7:00 p.m., revealed Resident #32 had yelled out in pain during incontinence care and resisted care when wipes touched her buttocks region. D. Staff interviews (continued on next page)

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North Shore Health & Rehab Facility	1365 W 29th St Loveland, CO 80538

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 was interviewed on 5/15/24 at 9:24 a.m. RN #1 said the resident's reaction during the incontinence care was typical for the resident during incontinence care. She said sometimes the resident hit her when she was providing incontinence care. RN #1 said she assumed, based on the resident's reaction, that her pain was a 10 out of 10. RN #1 said she did not notify a physician of the resident's pain and did not document it in the progress notes. Nurse practitioner (NP) #1 and the director of nursing (DON) were interviewed together on 5/16/24 at 9:14 am. NP #1 said she had seen Resident #32 during cares before and she had assessed her with catheter care the other day. She said even when there was no open wound, the resident would still complain of pain during incontinence care. NP #1 said the resident was very good about telling her that she was in pain. She said when staff was doing wound care in the past (when she had a documented open wound), the staff would pre-medicate the resident but that had not been the case for a while so she was not aware if her pain had gotten worse. -NP #1 was unaware the resident had a current open wound observed on the resident's buttocks (see observations above). NP #1 said the resident's family was somewhat resistant to medication changes. She said she did not think all of Resident #32's reaction during incontinence care was pain related. She said she thought some of it had been the transition to long-term care. She said the resident was used to being at home with her large family. She said she had a phone call with hospice later that day and they would also do another pain assessment to see if there was a change in the resident's condition. NP #1 said the resident's family had requested hospice services when the resident's decline started a few weeks ago. She said the last pain assessment documented on 4/12/24 was probably when the resident's decline started. NP #1 said she felt that the resident's dementia was part of what was contributing to her resisting care. She said she thought when the nurse heard the resident yelling in pain that the nurses might collaborate with social services and look at the care plan. The DON said nurses should document something in the progress notes which said what happened during the incontinence care and that the resident complained of pain. E. Facility follow-up On 5/17/24 at 5:34 p.m. (after the survey exit) the facility submitted the following documentation: 1. Record of pain audit performed 5/17/24 at 3:53 pm: 88 residents were audited for pain orders and documentation of pain level, and orders were in place. The audit was signed by the DON. An Interdisciplinary team (IDT) note, dated 5/16/24 at 3:43 p.m. documented the IDT was in collaboration regarding pain/anxiety/skin with the DON, social services director (SSD), RN #3, NP #2 and Resident #32's representative/power of attorney (POA). The IDT note read, in pertinent part, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pain management: pain is well controlled at this time, no need for changes identified. POA declined any changes to medications/pain plan of care for pain. -However, per the observations and RN #1's interview during the survey, Resident #32's pain was not well controlled during incontinence care (see observations and interviews above). 48112 III. Resident #1 A. Resident status Resident #1, over [AGE] years old, was readmitted on [DATE]. According to the May 2024 CPO, diagnoses included hemiplegia (paralysis on one side) and hemiparesis (weakness or inability to move one side of the body) post cerebrovascular disease affecting the left non-dominant side, a psychotic disorder with delusions, peripheral vascular disease (reduction in blood circulation), insomnia and depression. The 2/20/24 MDS assessment revealed the resident was cognitively impaired with a BIMS score of three out of 15. She had an impairment to the lower extremity on one side and used a wheelchair. She was dependent for oral hygiene, toileting hygiene, showering, dressing and personal hygiene. The resident was on a scheduled pain medication regimen, received as needed pain medication and non-pharmacological interventions for pain. The assessment revealed the resident was almost constantly in pain which frequently affected her sleep and the pain intensity was severe. B. Resident observation and resident representative interview The resident's representative was interviewed on 5/15/24 at 2:10 p.m. He said the resident complained to him a lot about pain on her right buttock from a wound. He said it was difficult visiting with the resident today (5/15/24) because the facility had just administered morphine and she was pretty drowsy. He said the facility had not found the right balance of medication so she could be awake to participate in her daily activities. -During the interview, Resident #1 was sitting in her wheelchair with two family members present. The resident's eyes were closed. C. Record review The pain care plan, revised 8/23/23, revealed the resident had pain related to arthritis, hemiplegia and contractures. Interventions included administering pain medication per orders, evaluating the pain intervention's effectiveness, monitoring and documenting the probable cause of each pain episode and monitoring and recording pain characteristics. -The care plan did not identify the location of the resident's pain or what non-pharmacological interventions were being provided to help alleviate the resident's pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pain assessment, dated 2/16/24, revealed the resident had pain due to cerebral vascular disease and cancer. She had pain in the past five days. She said the pain was sharp and throbbing. She said she could not sit up in a wheelchair for an extended period because it caused pain. She said the pain was worse mid day. Her acceptable level of pain was three out of ten. She said pain medication and position change relieved her pain. -The onset and duration of pain was not identified. The May 2024 CPO revealed the following physician's orders: Morphine sulfate 15 milligrams (mg). Administer 15 mg by mouth two times a day for pain, ordered2/20/24. Tylenol 500 mg. Administer two tablets by mouth three times a day for pain, ordered 2/20/24. Morphine sulfate 20 mg/ml (milliliter). Administer 0.5 ml by mouth every two hours as needed for pain and shortness of breath, ordered 4/12/24. Monitor pain every shift using a zero to ten pain scale. Acceptable level of pain is two, ordered 11/16/23. -The orders did not specify where the resident had pain and did not identify any non-pharmacological interventions for pain. Review of the May 2024 medication administration record (MAR) from 5/1/24 through 5/13/24 revealed the following: -The as needed morphine sulfate was administered at least once a day on 5/2/24 through 5/5/24 and 5/10/24 through 5/13/24. -The May 2024 MAR did not document where the resident had pain and did not identify if non-pharmacological interventions were offered when the as needed morphine sulfate was administered. A 5/13/24 nurse progress note said morphine sulfate 20 mg/ml was administered for pain. -The progress note did not document where the resident had pain and did not identify if non-pharmacological interventions were offered when the as needed morphine sulfate was administered. A 5/12/24 nurse progress note revealed the resident was yelling out all night. The nurse stayed with the resident and gave juice and water. The resident kept asking for her sister and complained of pain. At 1:15 a. m. the resident was administered as needed morphine and it was effective. -The progress note did not document where the resident had pain and did not identify if non-pharmacological interventions were offered when the as needed morphine sulfate was administered. A 5/4/24 nurse note revealed the resident complained of pain and was restless. As needed morphine and scheduled ativan was administered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The progress note did not document where the resident had pain and did not identify if non-pharmacological interventions were offered when the as needed morphine sulfate was administered. A 5/5/24 nurse progress note revealed the resident had an elevated blood pressure and pulse due to increased pain and fearfulness of being alone. As needed morphine was administered with scheduled ativan. Resident #1 was tearful and wanted her family to stay with her. The nurseried to provide comfort yet the resident was forgetful. -The progress note did not document where the resident had pain and did not identify if non-pharmacological interventions were offered when the as needed morphine sulfate was administered. D. Staff interviews Certified nurses aide (CNA) #4 was interviewed on 5/16/24 at 1:18 p.m. CNA #4 said she was familiar with Resident #1. She said the resident had pain in her leg, her back and her head. She said when she moved from her bed to her wheelchair it was one intervention that alleviated the resident's pain. CNA #4 said talking to the resident about her family also helped distract her from her pain. Licensed practical nurse (LPN) #1 was interviewed on 5/16/24 at 11:12 a.m. LPN #1 said pain assessments were completed for residents at admission and quarterly. She said the pain assessment addressed if the resident had any pain and if the resident had a diagnosis which caused pain. She said the pain assessment also addressed if the resident had scheduled or as needed pain medications and the location and severity of the pain. She said non-pharmacological interventions included redirection, reassurance and a calm environment. LPN #1 said she was familiar with Resident #1. She said she had pain on her coccyx, her left leg, back pain and generalized pain. She said repositioning helped minimize her pain. She said the minimum was to reposition the resident every two hours. LPN #1 said the resident was unable to shift her weight on her own so staff should reposition her to help with her pain. Nurse practitioner (NP) #1 was interviewed on 5/16/24 at 9:42 a.m. NP #1 said she was unsure if Resident #1 had pain. She said she was unable to identify the location of the resident's pain. NP #1 said it was possible when the resident's anxiety was high, the resident could be saying she was in pain. She said the lack of documentation by the nursing staff regarding Resident #1's pain made it difficult for her to provide direction to the facility on the best way to manage the resident's pain. She said hospice, the facility and the resident's representative needed to meet so everyone could be on the same page on what the goals were for her pain. The DON was interviewed on 5/16/24 at 11:44 a.m. The DON said pain assessments were completed at admission, quarterly and every shift. She said the pain assessment covered where the pain was located, what the pain management goal was and what non-pharmacological interventions helped alleviate the pain. She said the pain interventions were documented in the care plan and in the progress notes. She said she was familiar with Resident #1. She said the resident had pain but was unable to verbalize where the pain was. The DON said, in the past, the resident's pain was from her contractures and arthritis. She said she could check with the resident. She said the resident's care plan and orders needed to be updated to reflect what helped alleviate her pain besides pain medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review, observations and interviews, the facility failed to ensure one (#1) of five residents reviewed for unnecessary medications out of 31 sample residents were free from unnecessary medications. Specifically the facility failed to: -Ensure Resident #1 had appropriate non-pharmacological interventions for behaviors initiated; -Ensure Resident #1 was monitored for side effects of a psychotropic medications; and, -Ensure Resident #1 was monitored consistently for behaviors to justify the use of psychotropic medications. Findings include: I. Facility policy The Psychopharmacological policy, revised 3/10/23, was provided by the director of nursing (DON) on 5/16/24 at 1:44 p.m. It read in pertinent part, Licensed nurses and additional staff will monitor and document any targeted behaviors that occur. The care plan will include the resident's focus and target behaviors for the medication. Realistic and measurable goals will be utilized and approaches will include alternatives to psychopharmacological drug use. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on 7/9/99 and readmitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side) and hemiparesis (weakness or inability to move one side of the body) post cerebrovascular disease affecting the left non-dominant side, a psychotic disorder with delusions, peripheral vascular disease (reduction in blood circulation), insomnia and depression. The 2/20/24 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for a mental status (BIMS) score of three out of 15. She had an impairment to one lower extremity and used a wheelchair. She was dependent on staff assistance for oral hygiene, toileting hygiene, showering, dressing and personal hygiene. B. Observations (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was observed during a continuous observation on 5/13/24, beginning at 11:15 a.m. and ending at 11:33 a.m. The following observations were made: Resident #1 was lying in bed and had her legs bent to her right side at 45 degrees. The sheets and blankets were pushed to the end of the bed. She yelled nurse thirteen times between 11:15 a.m until 11:27 a.m. At 11:22 a.m. an unidentified certified nurse aide (CNA) walked into the room across from Resident #1's room when the resident was asking for a nurse. -The unidentified CNA did not acknowledge Resident #1 when she was calling out for a nurse and the resident continued to call out. At 11:27 a.m. the unidentified CNA entered Resident #1's room and asked if she wanted to get out of bed for lunch. -However, the CNA proceeded to leave Resident #1's room without getting the resident out of bed and the resident continued to call out. From 11:27 a.m until 11:33 a.m. the resident yelled nurse and I need help ten times. At 11:33 a.m. CNA #4 walked into the resident's room (five minutes after the previous CNA had initially entered the room) and asked Resident #1 if she wanted to get out of bed for lunch. C. Record review The 2/16/24 care plan revealed the resident used hypnotic, sedative and sleep disorder medications related to anxiety and agitation with expressed difficulty sleeping as evidenced by calling out at night. Interventions included a gradual dose reduction of Restoril (initiated 5/15/24), review medications with the interdisciplinary team (IDT) quarterly and as needed and attempt gradual dose reduction when clinically indicated (initiated 2/16/24). The 6/29/23 care plan, revised 9/15/23, revealed the resident used an antidepressant medication related to generalized anxiety. Interventions included to monitor, document and report adverse reactions to antidepressant therapy, changes in behavior and to review medications with IDT quarterly. The 8/28/23 care plan revealed the resident used an antipsychotic medication for symptoms and behaviors associated with psychotic disorders with delusions. Interventions initiated on 8/28/23 included to monitor for side effects and effectiveness, behavior monitoring and to review medications with the IDT quarterly. The May 2024 CPO revealed the following physician's orders: -Duloxetine (medication used to treat depression and anxiety) 60 milligrams (mg). Administer 60 mg by mouth in the morning for anxiety, ordered 1/15/24. -Mirtazapine (medication used to treat depression) 15mg. Administer 15 mg by mouth at bedtime for anxiety and depression, ordered 2/5/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Restoril (medication used to treat insomnia) 15 mg. Administer 7.5 mg by mouth in the evening for sleep for 14 days, ordered 5/11/24. -Lorazepam (medication used to treat anxiety) 2mg/ml (milliliters). Administer 0.5 ml by mouth three times a day for anxiety, ordered 5/10/24. -Review of the May 2024 medication administration record (MAR) revealed there was no documentation the medications were monitored for effectiveness and side effects. -The May 2024 MAR revealed there was no documentation Resident #1's behaviors were consistently monitored. -The May 2024 MAR revealed there no documentation non-pharmacological interventions were attempted with Resident #1 when she was exhibiting behaviors, such as calling out. -There was no documentation in Resident #1's electronic medical record (EMR) to indicate the facility was monitoring the resident for the effectiveness of the medications or potential side effects of the medications. -There was no documentation in the resident's EMR to indicate the facility was consistently monitoring the resident for behaviors or that staff were attempting non-pharmacological interventions to address the resident's behaviors. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/16/24 at 11:10 a.m. LPN #1 said she continuously monitored for resident's for behaviors. She said it was not consistent where she documented the behaviors. She said some residents had an order to monitor behaviors so she documented the behavior in the treatment administration record (TAR). LPN #1 said the resident did not have an order to document behaviors in the TAR then she documented in a progress note. She said she monitored residents for side effects of psychotropic medications based on if the resident was sleepy, had agitation or if there was a change in the dose of the medication. She said she documented side effects in the TAR. LPN #1 said non-pharmacological interventions included companionship, social service intervention, room changes, contacting the family and activities. She said she was familiar with Resident #1. She said she monitored the resident's behavior. She said the resident's behavior included she did not want to get out of bed. She said sitting with the resident helped the resident's behavior and the family helped too. LPN #1 said one on one care would be helpful for Resident #1. She said she monitored side effects of her medications. She said the resident's Duloxetine was decreased a while ago and the resident yelled more, had agitation, confusion and helplessness. She said the resident was very lonely. LPN #1 said she had not documented Resident #1's behavior, if non-pharmacological interventions were offered or if there were side effects. She said the medication was given to reduce fearfulness, loneliness, pain and agitation. She said Resident #1 responded well to music, a stuffed monkey was comforting, putting a pillow between her legs, doing her hair and offering fluids. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse practitioner (NP) #1 was interviewed on 5/16/24 at 9:42 a.m. NP #1 said Resident #1's anxiety was not managed. She said hospice, the facility and the resident's representative needed to meet so everyone could be on the same page on what the goals were for her anxiety. She said without the behaviors documented it was hard to provide direction to reduce the resident's anxiety. The DON was interviewed on 5/16/24 at 11:44 a.m. The DON said the facility did not document medications were monitored for effectiveness and side effects. She said the facility did not document that behaviors were monitored and if non-pharmacological interventions were offered. She said it was important to document because it helped determine if gradual dose reduction was an option for a medication, if the resident needed the medication and if the resident should continue to have the medication. IV. Facility follow up The DON sent a physician's progress note on 5/20/24 (after the survey). The 5/17/24 physician progress note revealed Resident #1 continued to have periods of restlessness, that in the past, were managed with antipsychotics. The medications were no longer appropriate but her anxiety and sleep issues were being addressed with benzodiazepines (depressant medications). The resident was non-ambulatory and the benefit of these medications for quality of life outweighed the potential risks that would occur if she were ambulatory. There would continue to be a collaborative and interdisciplinary approach to the care of the resident. -However, the physician's progress note was dated on 5/17/24, the day after the survey exit, and failed to address the monitoring of medication side effects, behavior monitoring or non-pharmacological interventions.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47151 Based on observations, record review and interviews, the facility failed to ensure residents received food and fluids prepared in a form designed to meet his or her needs. Specifically, the facility failed to ensure residents who were prescribed mechanically altered diets had food prepared according to their diet order of level six soft and bite-sized texture as indicated on their meal tray cards. Findings include: I. Professional reference The International Dysphagia (difficulty swallowing) Diet Standardization Initiative (IDDSI) (a tool to standardize mechanically altered diets and liquids) (January 2019), was retrieved on 5/21/24, from https://iddsi.org/Resources/Patient-Handouts read in pertinent part, Level six soft and bite-sized, for safety avoid these food textures that pose a choking risk for adults who need level six soft and bite-sized food: -Bread (no regular dry bread, sandwiches or toast of any kind). Use IDDSI level five minced and moist sandwich recipe to prepare bread; use pre-gelled 'soaked' breads that are very moist and gelled through the entire thickness; -Food with skins or outer shell foods with husks such as peas, grapes, chicken skin, salmon skin, and sausage skin. II. Record review The diet spreadsheet for level six (soft and bite-size) mechanically altered diets was provided by the consulting registered dietitian (CRD) on 5/15/24 at 4:30 p.m. The soft and bite-size texture spreadsheet documented the following modifications for menu items served during the lunch meal on 5/15/24: -The green peas were to be omitted and sliced cooked carrots served instead; and, -The wheat dinner roll was to be omitted and a slice of puree bread produced from a commercially prepared mix was to be served instead. -The facility failed to ensure the residents who were prescribed a soft and bite-size mechanically altered diet received foods that were altered to the correct texture for the lunch meal on 5/15/24. -Residents prescribed the level six soft and bite-size diet were served a regular wheat roll for lunch and green peas. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Meal service observation and staff interviews During a continuous observation of the lunch meal service on 5/15/24, beginning at 11:30 a.m. and ending at 12:55 p.m., the following was observed: The posted menu in the dining room documented the lunch meal consisted of baked chicken, peas, baked potatoes, wheat roll, and fruit crisp. -According to the diet spreadsheets (see above), the level six soft and bite-size restricted regular wheat rolls and peas. The diet spreadsheets indicated a sliced puree bread made with a commercial mix and cooked sliced carrots were to be served instead of a regular wheat roll and peas. At 11:45 a.m. service for the lunch meal began. Between 11:30 a.m. and 12:15 p.m., nine meal plates were assembled and delivered to residents who were prescribed a level six soft and bite-size mechanically altered diet. -The nine plates included a regular roll and peas instead of the puree bread slice and cooked sliced carrots. -At 12:00 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll; -At 12:01 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll; -At 12:15 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll; -At 12:16 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll; -At 12:18 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll; and, -At 12:22 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll. The dietary manager (DM) was interviewed on 5/15/24 at 12:23 p.m. during the lunch meal. The DM said the facility served a regular wheat roll and peas to the residents who were prescribed a soft and bite size texture and had done so in the past. The DM said recipes and menu spreadsheets for the level six soft and bite size texture were in the kitchen and kept in binders. At 12:24 p.m. the DM reviewed the recipes for wheat rolls and peas in the binders in the kitchen. -Neither the recipe for the peas or the wheat roll listed a modification for mechanically altered diets on the recipe. -The DM did not review a diet spreadsheet (see above) after reviewing the wheat roll and pea recipes and dietary staff continued to serve residents prescribed the soft and bite-size texture diet a regular wheat roll and peas. -At 12:26 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Shore Health & Rehab Facility	1365 W 29th St Loveland, CO 80538

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:44 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll; and, -At 12:46 p.m. a soft and bite-size plate was served that included peas and a regular wheat roll. The DM was interviewed again on 5/15/24 at 12:50 p.m., during the lunch meal service. The DM said the facility had not yet switched to using a commercially prepared puree bread mix to offer at meals. The DM said the puree mix was for residents on the level five mince and moist texture diet and not the level six soft and bite-size texture diet. IV. Additional staff interviews The DM was interviewed a third time on 5/16/24 at 9:00 a.m. The DM said the facility had offered the IDDSI diet textures for approximately a year. The DM said the diet spreadsheets were in the kitchen for the lunch meal served on 5/15/24, however, she said cook (CK) #2 did not refer to the spreadsheet to prepare the modified textures. She said the cooks tried to use the spreadsheets as much as possible. The DM said she was concerned the residents would not like the commercially prepared puree bread mix. The DM said the facility had been offering regular rolls to residents on the level six soft and bite-sized mechanically altered diet, however, the DM said she had scheduled an inservice for the following week to begin using the puree bread mix. The DM said she started a plan and put together staff education because further training was needed for the dietary staff on mechanically altered diet production. -The DM initiated the date for the inservice and the action plan during the survey. The registered dietitian (RD) was interviewed on 5/16/24 at 9:00 a.m. The RD said she audited the diets in the residents' electronic medical records (EMR) to ensure the prescribed diets matched what was on the residents' meal tickets. The RD said there had been no recent changes to many of the residents' diet orders. Dietary aide (DA) #2 was interviewed on 5/16/24 at 10:20 a.m. DA #2 said she did not cook but helped assemble and plate residents' meals. DA #2 said she knew the diet spreadsheets were located in the binders in the kitchen. DA #2 said the diet spreadsheets used to be posted near the back preperation table but were no longer posted so she asked the cooks which diet modifications were to be served during meals. The executive chef (EC) was interviewed on 5/16/24 at 10:30 a.m. The EC said he was not fully trained on how to use the diet spreadsheets and had not used the spreadsheets previously to prepare the mechanically altered diets. The EC said the modifications on the spreadsheets were to help reduce the risk of choking and swallowing issues for the residents. V. Facility follow up The quality mentor (QM) provided additional information on 5/18/24 (after the survey) at 9:00 a.m. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An action plan with an identified concern of following portions, extensions and diets was identified and created on 5/15/24 (during the survey). The plan included for staff to follow portion sizes, diet extensions and changes as listed on the diet spreadsheets with bimonthly meal observations to occur.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, interventions and record review, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically the facility failed to: -Ensure the high temperature dish washing machine functioned at the proper temperatures for one of two facility dish washing machines; -Ensure, for a high temperature dish washing machine, an irreversible registering surface temperature indicator (test strip) was present at the facility and readily accessible for measuring the utensil surface temperature; and -Ensure staff performed proper hand hygiene while plating and serving resident meals. Findings include: I. High temperature dish washing machine not at proper temperature and failure to monitor with an irreversible registering temperature indicator (test strip) A. Professional reference The Colorado Retail Food Regulations, ([DATE]), retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations, read in pertinent part, A warewashing machine and its auxiliary components shall be operated in accordance with the machine's data plate (label) and other manufacturer's instructions. The temperature of the hot water sanitizing rinse as it enters the manifold (dish washing compartment) may not be less than 180 degrees fahrenheit (F). In hot water mechanical warewashing operations, an irreversible registering temperature indicator (test strip) shall be provided and readily accessible for measuring the utensil surface temperature. After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in: Hot water mechanical operations by being cycled through equipment achieving a utensil surface temperature of 160 degrees fahrenheit (F) as measured by an irreversible registering temperature indicator; chemical, manual or mechanical operations, including the application of sanitizing chemicals by immersion with a contact time of at least 10 seconds for a chlorine solution. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times shall meet the criteria specified under sanitizers, criteria, shall be used in accordance with the EPA- registered label use instructions, and shall be used as follows: a chlorine solution shall have a minimum temperature based on the concentration and ph of the solution as listed in the following chart concentration range (mg/l). Mg/L means milligrams per liter, which is the metric equivalent of parts per million (ppm). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM said she had long term dietary staff and those staff members assisted training the new staff how to wash dishes and monitor the dish machine temperatures. The DM said all dietary staff washed dishes in the dish machine except for the cooks. The DM said she had not yet followed up the training staff (during the survey) since the issue with the dish machine was identified. The DM said she was not aware of the dish machine instructions on the label prior to the survey, but she began showing the staff the label (during the survey) and planned to incorporate the label instructions as part of staff training on the dish machine. The DM said staff were now to notify her, the chef, the ESD, or the administrator if the dish machine was not working correctly. The DM said she planned to change how she monitored the functionality of the dish machine and how the staff monitored the dish machine temperatures, and would check the dish machine every morning to verify staff monitored and recorded the sanitizer ppm properly and require that staff demonstrate how to monitor the sanitizer ppm. The consulting registered dietitian (CRD) was interviewed on [DATE] at 9:10 a.m. The CRD said the gauge on the dish machine had been replaced (during the survey) and the booster heater for the dish machine was faulty so the facility would continue with a chemical sanitizer for the dish machine. Dietary aide (DA) #2 was interviewed on [DATE] at 10:20 a.m. DA #2 said the dish machine in the kitchen had been adjusted (during the survey) to be used with a chemical sanitizer instead of high temperature sanitizing. She said she used the machine to wash dishes on occasion and the temperature for rinse sanitizing should be 180 degrees and temperature indicator strips could be used to test the temperature during the rinse cycle. She said if the dish machine temperatures were below the minimum standard she would stop washing dishes and tell a supervisor immediately. She said she had not identified any temperature issues with the dish machine prior to the survey. E. Facility follow up The quality mentor (QM) provided additional information on [DATE] (after the survey) at 9:00 a.m. A kitchen education was provided to the dietary staff on [DATE] at 6:30 p.m. by the NHA. The inservice provided instructions (below) on how to test the chemical sanitizer concentration of the dish machine and corrective action. The dish machine sanitizes by using correct sanitizer measured with sanitizing test strips. Sanitizing strips should measure 50 ppm for proper sanitizing of dishes and utensils. If the strip did not turn the correct color, measure using another test strip. Make sure the strips were not expired and did not show signs of wetness and contamination. Measure the water immediately after the rinse cycle by collecting a drip from the door. Record ppm measured and temperature of the machine on the proper recording sheet. If the machine test (verification) was not correct, contact a supervisor and/or kitchen repair vendor. If in doubt, serve food on disposable products until the dish machine was repaired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An inservice covering how to properly record dish machine chemical sanitizer ppm was provided to the dietary staff on [DATE]. The updated dish machine log listed the updated minimum temperature standards for the dish machine as 120 degrees F and the minimum sanitizer concentration as 50 ppm and staff were to report inappropriate temperatures or sanitizing issues to the supervisor immediately for corrective action. An action plan with an identified concern of the dish machine not at optimal temperature of 180 degrees F (rinse temperature) was identified and created on [DATE]. The plan included the following steps: Call for repair for machine and evaluation for booster (heater); the high temperature dish machine was converted to a chemical sanitizing machine and reviewed with the chemical company; appropriate test steps were in place for checking sanitizing levels; and, an inservice was created for staff on recording sanitation levels, checking temperature and proper test strips; director/chef was to check recording daily and verify as needed. II. Ensure staff performed proper hand hygiene while plating and serving resident meals A. Professional reference The Colorado Retail Food Regulations, ([DATE]), retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations, read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: After touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; after handling soiled equipment or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with raw food and working with ready-to-eat food; Before donning gloves to initiate a task that involves working with food; After engaging in other activities that contaminate the hands. B. Observations During a continuous observation of the lunch meal service on [DATE], beginning at 11:30 a.m. and ending at 12:50 p.m., cook (CK) #1 was observed touching her mask and hair with her hands and then handing clean dishes throughout resident meal service: At 11:47 a.m. while standing at the steam table where the lunch meal was held hot for the lunch meal service, CK #1 touched her mask with both hands. Without performing hand hygiene CK #1 picked up a plate with one hand and a serving utensil with her other hand and dished food onto the plate. CK #1 placed the plate of food in the serving window to be served to a resident. CK #1 picked up a soup bowl with one hand and with her other hand picked up a utensil to scoop food into the soup bowl. CK #1 then touched her mask, picked up a lid and placed the lid on the soup bowl. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:22 p.m CK #1 touched her nose with her left hand and then donned (put on) single use gloves without washing her hands. CK #1 used a knife to cut a food item on the steam table and used the knife and her gloved hand to place the food item on a plate. CK #1 discarded her gloves then touched her mask with both hands. CK #1 then picked up a plate and a serving utensil and continued to assemble meal plates to be served to residents. At 12:30 p.m CK #1 picked up a styrofoam cup and filled the cup at a juice machine in the kitchen. CK #1 pulled her mask down below her mouth and drank from the cup while walking through the kitchen and into the break room. CK #1 returned to the steam table, did not perform hand hygiene and placed a four ounce dish of food in the window. CK #1 continued to assemble resident meal plates to be served to residents. D. Staff interviews DA #2 was interviewed on [DATE] at 10:20 a.m. DA #2 said she had received hand hygiene education from the facility's infection preventionist (IP). She said staff should wash their hands anytime the staff changed tasks in the kitchen and wash their hands in between glove changes. DA #2 said gloves should be worn to handle raw meat. She said hand hygiene needed to be performed anytime someone entered the kitchen. DA #2 said hand hygiene needed to be performed after touching a face mask or hair. The DM was interviewed on [DATE] at 9:00 a.m. The DM said the facility's IP provided education to the dietary staff that included how to properly wash hands and when to perform hand hygiene. The DM said the IP included in the education that staff needed to wash their hands after touching their mask. The DM said if a staff member touched their mask or hair during food preparation the staff member should wash their hands E. Facility follow-up The QM provided a hand washing inservice on [DATE] (after the survey) at 9:00 a.m. The hand washing in-service was provided to dietary staff on [DATE] and included the following topics:education for food and nutrition staff on the proper usage of masks and gloves and hand washing. Staff must wash their hands after touching face masks, face or any part of the body before returning to serve (meals) or prepping foods. The inservice included a demonstration with return demonstration from the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065129	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Shore Health & Rehab Facility	1365 W 29th St Loveland, CO 80538

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations and staff interviews, the facility failed to maintain an infection control and prevention program designed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections in one of three units. Specifically, the facility failed to: -Follow proper infection control processes for cleaning and disinfecting lifts and vital signs equipment on the Parkview unit; and, -Use proper infection control procedures during a vaccination clinic. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC) Guidelines for Environmental Infection Control in Healthcare Facilities (2019), retrieved on 5/25/24 from https://www.cdc.gov/infection-control/hcp/environmental-control/index.html, read in pertinent part, Careful cleaning of patient rooms and medical equipment contributes substantially to the overall control of Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-intermediate Staphylococcus aureus (VISA) and Vancomycin-resistant Enterococci (VRE) transmission. Direct patient-care items (blood pressure cuffs) should be disposable whenever possible when used in contact isolation settings for patients with multiply resistant microorganisms. Non-critical items (those that come in contact with intact skin but not mucous membranes), are divided into noncritical resident care items (blood pressure cuffs, stethoscopes, wheelchairs, therapy equipment) and noncritical environmental surfaces (bed rails, bedside tables). They require cleaning followed by either low or intermediate level disinfection following manufacturers' instructions. Disinfection should be performed with an Environmental Protection Agency (EPA)-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA-registered disinfectant products must be followed (use-dilution, shelf life, storage, material compatibility, safe use and disposal). II. Mechanical lifts (sit-to-stand machine) and vital signs equipment A. Observations On 5/13/24 at 1:44 p.m. certified nurse aide (CNA) #1 was observed bringing the sit-to-stand mechanical lift out of a resident's room on the Parkview unit. CNA #1 took the equipment to a holding area with other lifts and left the lift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA #1 failed to disinfect the sit-to-stand mechanical lift after using the lift with the resident. On 5/15/24 during a continuous observation, beginning at 11:06 a.m. and ending at 11:20 a.m., an unidentified CNA was observed using a vital signs machine. The unidentified CNA was observed leaving a room on the Parkview unit with the vital signs machine and equipment, including blood pressure cuffs, a pulse oximeter, and a thermometer. -There were no cleaning wipes stored with the equipment. -The unidentified CNA wheeled the equipment down the hall and placed it next to the nurses' station. The CNA failed to disinfect the vital signs machine and equipment C. Interviews The infection preventionist (IP) was interviewed on 5/15/24 at 4:06 p.m. The IP said she had been working at the facility since 2020. She said the cleaning policy for vital signs equipment depended on if there was an outbreak. She said hydrogen peroxide was readily available and more gentle on skin and the equipment. The IP said the dwell time for hydrogen peroxide was about 30 seconds. She said if there was a range for the dwell time, she usually recommended the longer time listed, but she did not usually see a range. She said disinfection of the equipment depended on what was going on in the building. The IP said it was okay to clean all the equipment with the same wipe, however, she said it should be done after each use with a resident. She said CNAs were responsible for cleaning the equipment after every use with the hydrogen peroxide wipes. 37166 III. Hand hygiene during vaccination administration A. Observations On 5/15/24 a contract pharmacist (CP) was administering vaccinations to the residents in the presence of the infection preventionist (IP). At 11:28 a.m. the CP was observed standing next to room [ROOM NUMBER]. She put clean gloves on, took band aids, peeled them on one end and stuck them to a sharps container. She used her gloved hands to adjust her skirt, took paper records from the cart and went into room [ROOM NUMBER]. She exited the room holding paper records and wearing the same gloves. -Without changing her gloves or performing hand hygiene, the CP proceeded to take two prefilled vaccine syringes from the cart, stuck one band aid on her watch and one bandaid on her gloved hand and approached the resident in room [ROOM NUMBER] to administer the vaccination. After administering the vaccination, the CP removed her gloves and exited room [ROOM NUMBER] holding both syringes in her hands. She placed the syringes into the sharps container on the cart. -The CP did not perform hand hygiene before documenting the vaccination in the resident's record and pushing the cart to the next room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:31 a.m. the CP approached room [ROOM NUMBER]. She put clean gloves on, without performing hand hygiene, stuck band aids to her glove and entered room [ROOM NUMBER] with two syringes. After administering the vaccinations to the residents, the CP exited the room with gloves on, threw the syringes into a sharps container and took her gloves off. -The CP did not perform hand hygiene prior to putting clean gloves on. -With the new pair of clean gloves on, she adjusted her shirt, organized paper records and pushed the cart to the next room still wearing the gloves. At 11:38 a.m. the CP approached room [ROOM NUMBER]. She put clean gloves on, without performing hand hygiene, stuck band aids to her glove and entered room [ROOM NUMBER] with two syringes. After administering the vaccinations to the residents, the CP exited the room wearing gloves, put the two syringes into a sharps container and removed her gloves. -The CP did not perform hand hygiene after she removed the gloves. B. Staff interviews The IP was interviewed on 5/6/24 at 4:15 p.m. The IP said the pharmacist that was administering vaccinations was from the contracted company. She said the CP was not an employee of the facility. The IP said band aids should not be placed on the sharps container as the sharps container was considered to be unclean from contact with syringes and blood products. The IP said once the CP had applied clean gloves, other potentially unclean surfaces such as the cart, paper records, personal clothes and pens should not have been touched. She said once gloves were removed after administering the vaccinations, the CP should have performed hand hygiene prior to reapplying clean gloves.