STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065351	A. Building B. Wing	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Care Center	320 N 8th St Holly, CO 81047

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31821 Based on observations and staff interviews, the facility failed to maintain a sanitary, orderly, and comfortable environment for residents in 14 of 25 resident rooms in two hallways. Specifically, the facility failed to ensure walls, halls, ceilings, floors, and doors were repaired, painted and properly maintained. Findings include: I. Initial observations Observations of the resident living environment was conducted on 3/29/23 at 8:47 a.m. revealed: room [ROOM NUMBER]A: There were four nickel sized holes underneath the resident's shelf next to his bed. The wall next to the resident's bed had an area 24 inches by 24 inches which had not been painted. The outlet box did not have a cover on it with the cable wire exposed. The lament in front of the sink had an area approximately eight inches long by two inches wide which was lifted. room [ROOM NUMBER]B: The resident's call light was wrapped around the grab bar in the restroom which made it inaccessible. room [ROOM NUMBER]B: There was a large chip of sheet rock approximately four inches in circumference next to the resident's door. room [ROOM NUMBER]B: The wall in the restroom had a section of peeling sheetrock approximately seven inches long by three inches wide. room [ROOM NUMBER]B: The restroom wall had four nickel sized holes from the wall mount toilet paper holder, which had been moved. The restroom door had a hole approximately seven inches long by three inches wide. There was a metal bracket where the television brackets had been removed. The wall behind the door had damage from the door knob hitting the wall which was approximately five inches long by four inches deep. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]B: The wall next to the sink had peeling and chipped sheetrock approximately six inches long by three inches wide. The wood frame next to the sink had three areas where the wood had peeling and splintering scraps. The wall above the bed had a section approximately eight inches by four inches where a light fixture had been removed. The wall had pea-sized holes. The restroom's call light was wrapped around the grab bar which made it inaccessible. room [ROOM NUMBER]B: The wall above the resident's headboard had three areas of unpainted patch work approximately 10 inches by six inches, five inches by four inches, and four inches by four inches. room [ROOM NUMBER]B: The ceiling had water damage approximately five feet by five feet and another area approximately four feet by four feet. The restroom did not have a call light. room [ROOM NUMBER]A: The wall at the end of the resident's bed had damaged sheetrock approximately six inches in circumference. room [ROOM NUMBER]B: The corner piece next to the sink had an area approximately three feet high by three inches wide of chipped and damaged sheetrock. The metal corner bracket was exposed. The wall in the restroom had peeling and damaged sheetrock approximately 12 inches long by three inches wide. The fire doors next to room [ROOM NUMBER]A had chipped and splintering wood approximately four feet high by three inches wide on the corner. room [ROOM NUMBER]B had a metal piece approximately 24 inches by 24 inches where the old air conditioner had been replaced. There was an air gap on the right side of the metal piece. room [ROOM NUMBER]A: The wall in the restroom was damaged from the wheelchair hitting the wall. The wall behind the commode had a hole approximately nine inches long by five inches wide. The bathroom door had the bottom lament peeling away from the bottom of the door. The wood frame next to the sink was chipped and splintering from the wheelchair hitting the corner. The entrance door had chipped and splintering wood approximately three feet high by three inches wide. The wall next to the air conditioner had a metal piece approximately 24 inches by 24 inches where the old air conditioner had been replaced. There was an air gap on the right side of the metal piece. room [ROOM NUMBER]B: The wood frame next to the entrance had chipped and splintered wood from the wheelchair hitting the wood frame. The laminate on the sink had an area approximately three inches in circumference. There was a metal bracket from a missing towel rack next to the sink. The shower room on the north east end of the hall had 16 dime sized holes in bottom of the wall close to the shower surround. The caulking around the base of the shower was black and peeling. II. Environmental tour and staff interview (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The environmental tour was conducted with the maintenance supervisor (MS) and nursing home administrator (NHA) on 3/30/23 at 9:15 a.m. The above detailed observations were reviewed. The NHA documented the environmental concerns. The MS said the facility utilized a computer system to identify environmental issues. The MS said he did not have any repair requisition requests for the above-mentioned items. The MS said he missed these repairs and the above-mentioned damage should have been repaired and addressed in a timely manner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31820 Based on observations, record review and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible; and each resident received adequate supervision and assistance devices to prevent accidents for two (#1 and #26) of three residents reviewed for accidents/hazards out of 15 sample residents. Specifically, the facility: -Failed to ensure a medication in Resident #1's room had a current order and was not kept at bedside; -Failed to ensure Resident #26 had fall interventions in place; and, -Failed to ensure an oxygen concentrator was plugged into an appropriate electrical supply. Findings include: I. Resident #1 A. Resident status Resident #1, age 70, was admitted on [DATE]. According to the March 2023 computerized physicians orders (CPO), diagnoses included intracranial injury (brain injury), bipolar disorder, and acute kidney failure. The 3/6/23 minimum data set (MDS) assessment did not assess the brief interview for mental status. No behaviors were noted. B. Observation and interview Resident #1 was interviewed on 3/27/23 at 10:00 a.m. During the interview the resident stated he was discouraged that the nursing staff did not apply the medicine I need for my legs. The resident was keeping a tube of Diclofenac gel in the nightstand. He said he had to apply the cream when he needed it. C. Record review The resident did not have a care plan for self-administration of medications. The resident did not have an order for Diclofenac gel. The resident did not have a self-medication evaluation completed for Diclofenac gel. D. Interviews (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 3/27/23 at 10:53 a.m. She said for a resident to have their own medications, the resident must complete an evaluation to ensure they were safe to administer the medication on their own. She said Resident #1 did not have an evaluation for self-administration for any medications. She said she could not locate a current order for Diclofenac gel. She said it was important to make sure the resident could administer the medication safely. The director of nursing (DON) was interviewed on 3/29/23 at 1:18 p.m. She said after LPN #1 notified her of the Diclofenac gel, the facility began an investigation to find out where the Diclofenac gel came from. She said the facility reached out to the physician about the Diclofenac gel. The provider wrote an order for Diclofenac gel, and the DON and nursing home administrator (NHA) completed a self-administration evaluation. She said it was important to ensure all medications residents took had a current order and residents who wanted to self-administer medications had an evaluation completed for safety. She said the pharmacy would send a new tube of Diclofenac gel. 31821 II. Resident #26 A. Resident status Resident #26, age under [AGE] years old, was admitted on [DATE]. According to the March 2023 computerized physician orders (CPO), diagnoses included cirrhosis (severe scarring) of liver, alcohol dependence, fracture of left patella (knee cap), adjustment disorder with mixed anxiety, and post-traumatic stress disorder. According to the 3/7/23 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had disorganized thinking and had difficulty focusing attention. She required limited assistance for bed mobility, transfers, grooming and toilet use. The MDS assessment revealed the resident had a fall prior to admission. The MDS asssessment revealed no wander guard. B. Observation and interview On 3/27/23 at 9:13 a.m. the resident was observed lying flat in bed sleeping and the bed was left in a high position. The resident did not have a fall mat next to her bed. The resident's call light was wrapped around the repositioning bar. LPN #1 was interviewed on 3/27/23 at 9:20 a.m. LPN #1 said she was familiar with the resident's care plan. LPN #1 observed the resident while she was sleeping. LPN #1 said the bed was supposed to be in a low position and she should have had a fall mat next to her bed per her care plan. LPN #1 said the negative outcome of care plan not being followed would be the resident could have another fall or a major injury. C. Record review Fall risk evaluation dated 3/13/23 identified the resident as being at a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan, initiated 3/1/23, identified the resident was at risk for falls. Interventions include: The resident needs a safe environment such as the bed in low position at night, personal items within reach, fall mats next to bed while the resident is in bed. The resident needs prompt response to all requests for assistance. The resident has a fluctuating ability to utilize call light. Provide consistent rounding and offer redirection as indicated. D. Interview The director of nursing (DON) was interviewed on 3/29/23 at 1:18 p.m. The DON was told of the observation above. She said it would be her expectation the care plan should have been followed and the bed would have been at the lowest position and the fall mat would be next to the bed. The DON said when staff assist the resident to bed they should place the bed in the lowest position. Staff should use the fall mat and keep her call light cord within reach. The DON said failing to provide care planned interventions could contribute to further falls for this high-risk resident. III. Failed to ensure oxygen concentrator was plugged into a medical grade power surge protector On 3/27/23 at 11:18 a.m., room [ROOM NUMBER]B had an oxygen concentrator, which was plugged into a regular power strip. It was not a medical grade power surge. The environmental tour was conducted with the maintenance supervisor (MS) and nursing home administrator (NHA) on 3/30/23 at 9:15 a.m. The above detailed observations were reviewed. The NHA said the oxygen concentrators should not have been plugged into the power strips. She said the oxygen concentrator was plugged directly into the room outlet after the environmental tour.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 31820 Based on record review and interviews, the facility failed to ensure licensed nurses were able to demonstrate competencies in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Specifically, the facility failed to ensure nursing staff had completed competencies in the past 12 months prior to providing skilled services as described in the plan of care for two out of two registered nurses (RN) and one out of one licensed practical nurses (LPN) reviewed for competencies. Findings include: I. Resident census and conditions According to the resident census and conditions provided by the nursing home administrator (NHA) on 3/27/23, the facility had: -Two residents with an indwelling catheter; and, -One resident with a pressure ulcer. II. Record review RN #1, RN #2, and LPN #2 did not have competencies completed for identified conditions in the facility specifically catheter care and wound care. III. Interviews The director of nursing (DON) was interviewed on 3/29/23 at 1:18 p.m. She said nursing competencies were important to ensure the residents were not put at risk and skills were performed safely. She said she had observed some of the skills performed by the nurses from standing afar, but did not have a formal return demonstration recorded.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31821 Based on observations, record review and staff interviews, the facility failed to ensure food was stored, prepared, and served under sanitary conditions in one kitchen. Specifically, the facility failed to ensure: -Appropriate hand hygiene by food service staff; and, -Food was stored and labeled properly Findings include: I. Improper hand hygiene A. Professional references According to the Colorado Retail Food Establishment Rules and Regulations (effective 1/1/19) pg. 46-47, in 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 items and: Before handling or putting on single use gloves for working with food, and between removing soiled gloves and putting on clean gloves. Food employees shall clean their hands and exposed portions of their arms including surrogate prosthetic devices for hands or arms with soap and water for at least 20 seconds and shall use the following cleaning procedure: 1. Vigorous friction on the surfaces of the lathered fingers, fingertips, areas between the fingers, hands and arms for at least 15 seconds, followed by; 2. Thorough rinsing under clean, running warm water; and 3. Immediately follow the cleaning procedure with thorough drying of cleaned hands and arms with disposable or single use towels or a mechanical hand-drying device. B. Observations Observation of meal service was conducted on 3/29/23 at 10:45 a.m. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dietary aide (DA) #1 was observed preparing hamburger meals for lunch. DA #1 put on a pair of gloves and walked into the walk-in freezer and removed a box of frozen hamburger patties and placed them next to the stove. She retrieved a large pan and placed it on the oven and turned on the gas burner. She opened the box with her gloved hand and removed five frozen hamburger patties with her gloved hand and placed them into the pan. She proceeded to seal up the box of hamburger patties and returned to the walk-in freezer. She opened the freezer door with her gloved hand and walked into the freezer placing the box into the freezer. She returned to the stove to check the hamburger patties. She then walked over to the walk-in refrigerator and opened the door with her gloved hand. She placed three plastic containers of tomatoes, onions and lettuce on the counter top in front of the walk-in refrigerator. She then returned into the walking refrigerator grabbing the door handle with her gloved hand. She exited the walking refrigerator with a jar of mayonnaise and placed it in the preparation area next to the stove. She checked the hamburger patties on the stove and proceeded to grab four plates. She then grabbed a bag of buns from the top counter. She reached in with her gloved hand and removed the hamburger buns placing them on the plate. She wiped her hands on the side of her pants as she reached up to get a pair of tongs. She took two plates with the hamburger buns over to the counter in front of the walk-in refrigerator and proceeded to grab a slice of tomatoes, a handful of lettuce and onion and place them onto the hamburger bun. She returned to the preparation area with the plates and put them on the counter. She walked over to the small refrigerator, opened the door with her gloved hands and retrieved a package of cheese. She opened the package of cheese and grabbed two slices with her gloved hand and placed them on the hamburger buns. She grabbed the tongs and grabbed two hamburger patties placing them onto the buns. She then opened the bag of chips and proceeded to use the same tongs she used to grab the hamburger patties and grabbed potato chips from the bag placing them on the plate. She then walked over to the serving line and placed plastic wrap over the plate of hamburger and chips. She leaned forward over the plate which allowed her badge to rest on the hamburger patty. The cutter on the box of plastic wrap was broken so she grabbed a pair of scissors and cut the plastic wrap with the scissors. She then placed the hamburgers on to the top of the serving line. She grabbed two more plates and proceeded the same process of preparing the other hamburgers. This time she used the same tongs to place the tomatoes, lettuce and onions onto the hamburger buns. She replaced the lids on the plastic containers and placed the tomatoes, lettuce and onions back into the walk-in refrigerator. She exited the walk-in refrigerator and proceeded to take the plates over to the preparation area. She again grabbed two slices of cheese and placed them on the bun. She then took the tongs and placed the hamburger patties onto the buns. She used the tongs again and removed chips from the bag, placing them onto the plate with the hamburger. She followed the same procedure of wrapping the plate with the plastic wrap and placing it onto the serving line. She then grabbed the tongs and other utensils and took them to the dishwashing area and placed them onto the dirty dishes side. She returned to the preparation area removing and discarding her used gloves and putting one new glove on without performing hand hygiene. She then proceeded to prepare peanut butter and jelly sandwiches. She grabbed four slices of bread with her one gloved hand and a plate and proceeded to spread the peanut butter onto the bread while holding the bread with her ungloved hand. She did this for two slices of bread. She walked over to the small refrigerator and removed a jar of jelly. She opened it with her gloved hand and proceeded to spread the jelly onto the bread holding one side of the bread with her ungloved hand. She placed the peanut butter and jelly sandwich on the cutting board and cut the sandwich in half. She grabbed the sandwich with her gloved hand and placed it on to the plate and placed it on the top of the serving line. She repeated the same process for one more sandwich of peanut butter and jelly. DA #1 did not perform hand hygiene during this process. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The cook was observed serving meals on the service line. She would constantly grasp her hand together while she was waiting for the next meal order. She left the serving line and proceeded to go to the dirty dish side of the dish room. She proceeded to rinse some utensils and returned to the serving line. She was observed grabbing several slices of bread to put on the plate. She did this twice and then proceeded to use tongs to grab the bread. The cook grabbed four assistive devices for bowls for a resident order. She had her thumbs inside the bowl while she was serving the pureed meals. The cook did not perform hand hygiene during this process. C. Staff Interview The dietary manager (DM) was interviewed on 3/29/23 at 2:05 p.m. She said all kitchen staff needed to wash their hands when their hands become contaminated. She said all staff must wash their hands before handling or serving food. She said staff should never touch ready to eat foods with their bare hands. She said they should use serving tongs even if they have gloves on. Staff should also wash their hands when they leave the kitchen and dining area. The DM said all dietary staff should wash their hands between tasks to avoid cross contamination. II. Labeling food A. Professional reference According to the State Board of Health Colorado Retail Food Establishment Rules and Regulations (effective 1/1/19) 3-602.11, 4 a-d. pg. 103, 4 a-d. in part, A date marking system that meets the criteria stated .using a method approved by the Department for refrigerated, ready-to-eat, potentially hazardous food (time/temperature control for safety food) that is frequently re-wrapped, such as lunch meat or a roast. Marking the date or day of preparation with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. Marking the date or day the original container is opened in a food establishment with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. Using calendar dates, days of the week, color coded marks or other effective marking methods. B. Observation On 3/27/23 at 7:30 a.m. during the initial tour of the kitchen items stored in the walk in freezer that were not labeled included: one box of hamburger patties, a bag of ravioli, box of fish filets, box of green peas, chicken breasts in a clear plastic bag, hotdogs in a clear plastic bag. On 3/29/23 at 11:00 a.m. items stored in the walk in freezer that were not labeled included: one box of hamburger patties, a bag of ravioli, box of fish filets, box of green peas, chicken breasts in a clear plastic bag, hotdogs in a clear plastic bag. C. Staff interview (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DM was interviewed on 3/29/23 at 2:05 p.m. She said all food should have been labeled to include the item and date. She said by doing so, it identified the product, so staff knew what they were grabbing and it was the correct product. She said it was important to date the items so the staff knew when to discard them. She said the proper time frame was seven days from the day the item was prepared, opened or pulled out of the freezer to thaw. She said the potential risk of not labeling was serving an incorrect food item and serving food past seven days from the day the item was prepared, opened or pulled out of the freezer to thaw.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 31821 Based on observation and staff interview, the facility failed to provide a safe, functional and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure a backflow prevention device was installed on a hose in the kitchen maintenance closet and on the hand held shower on the west hall shower, increasing the risk of contamination to the facility's main water supply. Findings include: I. Backflow prevention devices A. Professional references According to the Environmental Protection Agency's Cross-Connection Control, updated on 11/2/22, retrieved on 3/29/23 from: https://www.epa.gov/system/files/documents/2021-12/ds-toolbox-fact-sheets_ccc.pdf, it read in pertinent part, Cross-connections are actual or potential connections between a potable water supply and non-potable water plumbing. Backflow is the unintended reversal of water flow through a cross-connection, which can result in a potentially serious public health hazard. A cross-connection control and backflow prevention program helps prevent contaminants from entering a drinking water distribution system. This fact sheet is part of EPA's (Environmental Protection Agency) Distribution System Toolbox developed to summarize best management practices that public water systems (PWSs), particularly small systems, can use to maintain distribution system water quality and protect public health. B. Observation Observations of the resident living environment conducted on 3/29/23 at 8:47 a.m. revealed: The kitchen maintenance closet had a hose which was utilized to fill the mop bucket. The hose in the kitchen maintenance closet did not have a backflow prevention valve on it. The sink was approximately 20 inches long by 20 inches wide and six inches deep. The sink was set on the floor with a long hose approximately 48 inches long sitting at the bottom of the yellow mop bucket. The mop bucket had visible water on the bottom. The hand held shower in the west shower room was positioned on the floor of the shower pan and was constantly running. The backflow prevention valve was nonfunctional as it was leaking. The hand held shower was long enough to sit on the side on the floor next to the drain. There was visible standing water at the base of the shower pan and the hand held shower had a continuous flow of water coming out of the end of it. II. Staff Interview (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Care Center	320 N 8th St Holly, CO 81047

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The maintenance supervisor (MS) was interviewed on 3/30/23 at 9:15 a.m. He acknowledged he was familiar with the backflow valve protocol. The MS observed the hand held shower in the west shower room and the kitchen maintenance closet. The MS stated the hose in the kitchen maintenance closet was used to fill the mop bucket, and it should have had a backflow prevention valve on it. He said the hand held shower hose on the west shower room should have had a functioning backflow prevention valve as it was visibly leaking. He said he would have to investigate why the water was constantly running. He said the west shower room did not have a functioning backflow preventer valve on the hand held shower head, and the hose in the kitchen maintenance closet should have had a backflow prevention valve on it. He said she would place the backflow valves on them immediately.