STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. BUILDING _____ B. WING _____	06/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure grievances from the group were provided prompt efforts by the facility to resolve a grievance. Cross-reference F806 (Preferences and Substitutes) and F809 (Frequency of meals and snacks) Findings include: I. Facility policy and procedure The grievance policy was delivered on 6/4/2020 by the director of operations (DOO). Policy Statement All grievances and complaints filed with the facility will be investigated and corrective action will be taken to resolve the grievances. Policy Interpretation and Implementation The administrator will assign the responsibility of investigating the grievances and complaints to the grievance officer. The investigation report will include : The date and time of incident The circumstances surrounding the incident The names of any witnesses Accounts given by residents or employees Recommendations for corrective action A copy of the grievance form must be signed and returned to be filed in the business office. Copies of all reports must be signed and will be made available to the resident or the person acting on behalf of the resident. II. Food committee minutes The food committee notes dated 4/30/2020 included the residents had requested menus before the meals.The residents also asked for an alternative meal if the meal being served was not suitable for them.The notes revealed the residents wanted to be served their food on time. They were tired of getting their food late and cold. The food committee notes on 5/26/2020 requested for the residents to be offered alternative choices at meal times.The resident asked for a bigger variety of snacks to be offered at snack time. Two suggestions were fresh fruit and fresh vegetables.The residents had requested for the meals to be served on time The facility was unable to provide any documentation that showed the grievances from the group were resolved. III. Observations Cross-referenced F 806 and F 809 showed the facility continued to have complaints from residents in regards to no menu, no preferences and lack of snacks, and meals continued to be served late. The posted dining room meal times were: 7:30 a.m. Breakfast 12:30 a.m. Lunch 5:30 p.m. Dinner Late meals 5/28/2020 Noon meal --At 1:00 p.m., one of two food carts was brought to the unit. --At 1:05 p.m., the staff began passing the food to the residents in their rooms --At 1:10 p.m. the resident in room [ROOM NUMBER] received her lunch. -- At 1:20 p.m.Resident #2 called out to the staff for his lunch from the end of Oak hall. -- At 1:30 p.m. Resident #1 received her lunch. -- At 1:40 p.m. Resident #2 received his lunch in his room. 6/1/2020 Noon meal --At 12:50 p.m The lunch meal arrived in the unit. --At 1:06 p.m. Resident #1 received her food. --At 1:17 p.m. the resident in room [ROOM NUMBER] received her lunch from the director of nursing(DON.) 6/1/2020 Evening meal --At 4:45 p.m. the meal trays were being passed out. 6/2/2020 Evening meal -At 4:50 p.m., the meal trays were being passed to residents. 6/3/2020 Breakfast meal -At 8:46 a.m., breakfast was being served to the residents. Interviews The director of nurses (DON) was interviewed on 6/1/2020 at 3:05 p.m The DON said she assisted with the noon meal, she said she heard a lot of food complaints on the Shepard's pie. Resident #6 was interviewed on 6/3/2020 at approximately 1:00 p.m. The resident was the resident council president. He said when the council met, the residents would bring up concerns about the food, menus, lack of snacks and lateness of the meals. However, the complaints were never resolved. The NHA was interviewed on 6/2/2020 at 12:45 p.m. He said the residents had a food committee and they met once a month. He said the food committee notes were included in the resident council comments for April and May of 2020. He included that he heard the food was both good and bad. He did not realize there were a lot of complaints about the food from the residents. He could not produce recipes for the meals that were served.He included that grievances about the food were handled as a team. He agreed he should be out on the floor more often talking to the residents about the food. The social service director was interviewed on 6/4/2020 at 4:30 p.m. She said that either a staff member or the resident would fill out the grievance form and it would usually go to a specific department depending on the nature of the grievance. The facility had 5 days to resolve grievances or let residents know what was going on and if the facility needed an extension to do more investigations. She had not worked in the building since May 11th and just did prn work remotely.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual or desirable body weight range, resulting in significant/severe weight loss, affecting six (#1, #2, #3, #4, #5, #6) of six residents reviewed for nutritional status out of 11 total sample residents. Specifically: Upon identification of weight loss, the facility failed to identify, implement, monitor, and modify interventions consistent with the resident's assessed conditions, needs, choices, preferences and goals, in order to promote their nutritional status. These failures contributed to Resident #1 experiencing an 18 percent (%) (severe) weight loss, Resident #5 experiencing a 21% (severe) weight loss, Resident #2 experiencing a 9.71% (severe) in three months, Resident #3 experiencing an 11.85% (severe) weight loss in three months, Resident #4 experiencing a 9.57% weight loss in three months and Resident #6 experiencing a 6.61% (severe) weight loss in one month. Cross reference F803 (Menus), F806 (Preferences and Substitutes), F809 (Frequency of meals and snacks) and F841 (Medical Director) Findings include: I. Facility policy and procedure A. The Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 9:35 a.m. It revealed in pertinent part: The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time. The staff and physician will define the individual's current nutritional status and identify individuals with anorexia, recent weight loss, and significant risk for impaired nutrition. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a) 1 month - 5% weight loss is significant; greater than 5% is severe, b) 3 months - 7.5% weight loss is significant; greater than 7.5% is severe, c) 6 month - 10% weight loss is significant; greater than 10% is severe. The physician, with the help of the multidisciplinary team (IDT), will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequences of weight loss and/or impaired nutrition. The physician will review possible causes of weight loss with the nursing staff and/or dietician before ordering interventions. The physician (or staff, based on a discussion with the physician) will document relevant medical observations and, regarding the nature, severity, causes, and consequences of impaired nutritional status, especially in complex situations or where multiple, active causes may co-exist. The staff and physician will identify any pertinent interventions based on identified causes and overall resident condition, prognosis, and treatment wishes. Treatment decisions should consider all pertinent confirmation or evidence, such as food intake and overall condition. Nutritional needs: The dietician will help the physician determine the appropriate diet for the resident based on the resident's degree of nutritional impairment. Environmental factors: Staff will ensure that the food served to the resident has an appealing aroma, flavor, form, temperature, and appearance. Supplementation: Strategies to increase a

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

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) resident's intake of nutrients and calories may include fortification of food, providing between-meal snacks and/or nutritional supplementation. The physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include: Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals; Evaluating the resident's response should be based on defined criteria for improvement/worsening of nutritional status; Observing for and documenting any sustained decline in appetite and/or food intake; and Observing for and reporting significant weight gain and/or loss. B. The Weight Pathway Policy was provided by the NHA on [DATE] at 9:35 a.m. It read, in pertinent part: In the event the weight of the resident varies +/- three lbs from the prior weight, the restorative aide must solicit the treatment and lead to witness a reweight. In the event the weight remains the same it will be documented, with two separate entries, and reweighed the following day. In the event the weight still varies the following day, a progress note will be made, the doctor and registered dietician (RD) made aware of change, and change of condition process started for nurses where they document every shift on the encouragement of fluids if applicable, intake of residents, or any change in eating patterns. The interdisciplinary team (IDT) will meet to review weights. The weight summary report should be pulled with a six month lookback for review. These will be the weights to review, no other report to be utilized. It is the expectation that the director of nursing (DON) would attend the monthly weight meeting. Weekly weights determined in the meeting were based on criteria of residents with greater than 3 lbs from the last weight, 5% in 30 days, 7% in 90 days or 10 % in 180 days. All interventions are to be care planned in the moment at IDT for any resident that is added for review every week. Nutrition at Risk (NAR) meetings should include minimally the Director of Nursing, and the dietary manager, weekly. The Dietician, Social Services, activities and administrator should be included monthly in the initial meeting for the month. Ensure actual intakes are reviewed prior to the NAR meeting and every day. Use the alert on your dashboard as a way to guide the staff to be proactive. That information is something the dietary manager should assess. Minimum intake for fluids, food, and protein will be based on your Dietician's assessment so please ensure documentation is occurring. When performing a NAR review and determining interventions ensure you recap what was previously tried, review the care plan and ensure implementation is plausible. 1. Interviews The DON was interviewed on [DATE] at 3:05 p.m. The DON said if the weight was off, and the resident had a weight loss of plus or minus three pounds, then the resident should be reweighed within 48 hours. She said the scale had been calibrated within the past 60 days. The DON was interviewed a second time on [DATE] at approximately 4:00 p.m. She said the scale was calibrated on [DATE]. II. Facility failure to take steps to promote residents' nutritional status upon identification of weight loss. A. Resident #1 1. Resident status Resident #1, age 80, was admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The MDS dated [DATE] indicated the resident experienced a weight loss of 5% or more in the last month or a loss of 10% or more in last 6 months. The MDS revealed the resident weighed 126 lbs. The weights and vitals scale located in the residents chart offered the resident weighed 124.4 lbs on [DATE] and 117.2 lbs on [DATE]. A minimum data set assessment ((MDS) dated [DATE], coded the resident as having short-term memory impairments and modified independence with decision-making. She was coded as requiring oversight and encouragement with eating. The resident was 67 inches tall and weighed 126; her usual body weight was 140. The MDS documented the resident was not on a weight loss program. The resident's care plan, dated [DATE], read the resident was at nutritional risk and had unintended weight loss. The resident fed herself with cueing and reminders from the staff. Staff should offer snacks and fluids in between meals on a daily basis. 2. Record review revealed Resident #1 had a severe weight loss from [DATE] to [DATE]. Weight chart for Resident #1 revealed Resident #1 had an 18% weight loss from [DATE] to [DATE]. [DATE] at 14:19, she weighed 117.0 pounds (#) [DATE] at 12:55, she weighed 116.4 # [DATE] at 12:05, she weighed 117.2 # (a 4% weight loss from the ,[DATE] to [DATE]) [DATE] at 14:14, she weighed 122.2 # [DATE] at 17:04, she weighed 126.0 # [DATE] at 9:22, she weighed 143.0 # (an 11.89% weight loss from ,[DATE] to [DATE]) [DATE] at 10:05, she weighed 147.6 # [DATE] at 14:44, she weighed 148.2 # 3. Facility's response to Resident #1's weight loss Record review and interview revealed that although the resident's weight loss was identified in early May, interventions to address it were neither timely, effective, nor consistently implemented. Likewise, interventions were not modified as the resident continued to lose weight. a. Record review A doctor's note, dated [DATE], indicated the resident was seen for depression and weight loss. The orders for the weight loss were to recheck labs for the resident and to order a dietary consultation. The treatment plan revealed the patient was on isolation due to social coronavirus pandemic. The patient's roommate recently passed away. The doctor ordered 10 mg [MEDICATION NAME] with the associated [DIAGNOSES REDACTED]. -However, the resident did not see the dietician until [DATE] (see below), and from ,[DATE] to [DATE], the resident's weighed dropped 8.8 # or 9 % in two weeks. A MDS signed on [DATE], revealed the resident was not on a prescribed weight loss program and had a weight loss of five percent or more in the last month. -However, record review revealed no updates to the resident's [DATE] care plan, with preferences, directions to staff to offer alternates, or discussions with the resident's power of attorney (POA) or IDT on effective ways to promote the resident's intake. In addition, there was no evidence in the resident's care plan regarding the resident's depression, how staff might address it, and whether it was a factor in her weight loss. The care plan history dated [DATE] was revised by registered dietician (RD). It included the resident required meal assistance with reminding and cueing at meal times. She said the resident was a nutrition risk that was likely due to depression. The RD offered the resident was on a regular diet. A note by the dietician following a dietary consult, dated [DATE], revealed the resident was reviewed at the nutritional risk meeting and was at risk for weight loss. She was on a regular diet with no restrictions. She required cueing and encouragement to eat. The resident had refused the nutritional supplements. -However, the dietician's orders, also dated [DATE], read the resident was to be offered the supplement Ensure twice daily, in addition to snacks three times per day for weight loss and weights weekly. Review of the medication administration record (MAR) for [DATE] indicated the resident drank the supplement on only two days following the [DATE] order, refusing the supplement the rest of the month. There was no evidence staff investigated the resident's refusals or offered a different type of supplement in order to encourage intake. A nutrition note beginning [DATE] documented the resident's food intake from [DATE] back 14 days to [DATE]. It revealed poor intake. Specifically, the resident ate ,[DATE]% of food for 8 of the 14 days for breakfast, 25 to 50% on 2 of the 14 days for lunch, and refused to eat dinner (0%) for 9 of the 14 days. It also revealed the resident refused snacks on 100% of those 14 days. -However, there was no evidence staff investigated the resident's refusals, discussed preferences or alternates in order to encourage intake. Likewise, there was no evidence the facility considered her purported depression, its relationship to her weight loss and how staff might intervene. b. Observations revealed Resident #1's intake was minimal and staff failed to offer an alternate meal or encouragement, cueing and reminders to eat as care planned and ordered. [DATE] -At 12:55 p.m. the resident sat in her room with her noon meal in front of her, however, she was not eating. She appeared uninterested in the food and starting falling asleep in her chair. [DATE] -At 12:50 p.m., the lunch meal arrived in the unit. -At 1:06 p.m., Resident #1 received her food. The general nurse assistant (GNA) took the plastic off the resident's plate and left the resident's room. The GNA did not sit with the resident or engage her in conversation. The resident did not receive any encouragement, reminders or cueing from the GSA to eat her meal. -At 1:15 p.m., the resident took two bites of her food. Four minutes later, at 1:19 p.m., the GNA entered Resident #1's room and removed her tray. All of the resident's meal, except for the two bites she had taken, remained on her tray. The GSA did not encourage the resident to eat or offer an alternative meal. -At 1:27 p.m. the licensed vocational nurse (LVN) was informed the resident had not eaten her meal and her tray had been removed without an offer of an alternative meal. The LVN then approached the resident about receiving an alternative meal, like a soup or sandwich, and the resident refused the offer. Several minutes later, at 1:33 pm., Resident #1 ate a piece of dried fruit from a baggie on her table. [DATE] -At 4:40 p.m., the dinner meals arrived in the unit and at 4:58 p.m., Resident #1 received her meal. -At 5:03 p.m. Resident #1 ate one bite of food and declined to eat any more of her meal. She drank 200cc of coffee. Staff did not sit with the resident or engage her in conversation. Staff did not offer her an alternate meal or enter her room to cue or encourage her to eat. The resident was observed continuously until 5:09 p.m., asleep in her wheelchair when her tray was removed from her room. c. Interviews Certified nurse aide (CNA) #1 was interviewed on [DATE] at 3:00 p.m. She said she was familiar with Resident #1. The CNA said Resident #1 was able to feed herself but she needed reminders and cues from staff to eat, stating staff needed to sit with the resident to remind her to eat. She said the resident also needed staff to cut up her food. She further stated the resident had stopped eating after her roommate died . LPN was interviewed on [DATE] at 3:00 p.m. She said she was familiar with Resident #1. She said Resident #1 did not require assistance with eating. She said Resident #1 was a picky eater. She said that Resident #1 liked to sit in the dining room during meals and being isolated from other residents (during the pandemic) had affected Resident #1's appetite. She said Resident #1 usually ate three eggs and toast

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) or cereal for breakfast. The LVN said she would ask management if the resident could have her eggs for breakfast every morning. Resident #1's power of attorney (POA) was interviewed on [DATE] at 2:00 p.m. She said the facility had informed her of Resident #1's weight loss on [DATE]. She stated she was concerned about the resident and she thought Resident #1 was depressed due to the recent death of her roommate. The POA included she had taken snacks to the facility on [DATE] for Resident #1 after she found out about her weight loss. The registered dietician (RD) was interviewed on [DATE] at 9:30 a.m. She said she had discussed Resident #1's decline with the resident's nurse practitioner (NP) and said it sounded like the resident's decline was related to depression, likely due to the death of her roommate who passed away from the COVID-19. She said Resident #1 was close to her roommate and, then, she became isolated from everyone She said the resident's weight loss could have been avoided if the staff had spent more time offering the resident eating assistance. She said she had spoken to the NP about getting an appointment for the resident with a therapist, but nothing had been set up yet. B. Resident #5 1. Resident status Resident #5 was admitted to the facility on [DATE]. According to the CPO, [DIAGNOSES REDACTED]. According to the [DATE] MDS, the resident should be encouraged to eat his meal. His usual body weight per weight chart was 146 lbs. 2. Record review revealed the facility identified the resident was at nutritional risk at admission and losing weight. Orders were entered to monitor the resident and offer supplements. However, the facility failed to modify interventions as the resident continued to lose weight. a. Recognition of weight loss and facility response -On the care plan dated [DATE], shortly after admission, Resident #5 was identified at nutritional risk for weight loss secondary to dementia. The care plan recommended that he ate at least 75% of his meals. The resident should be encouraged to finish his meal. The resident should be offered substitutes if he does not like the meal served. -On [DATE], the resident was seen remotely by a nurse practitioner (NP). The primary concern was abnormal weight loss. The physician reviewed the resident's labs and spoke with the nurses about the resident's condition; the nurses said the resident had been eating and drinking. Monitoring of the resident was ordered. -The care plan dated [DATE] repeated the resident was a nutritional risk and should be monitored for weight loss. The resident was on a regular diet and should be offered snacks in between meals. The resident enjoyed cereal; however, staff had been instructed to offer the regular meals instead of the cereal. The cereal should be the last option. -A nurse's notes dated [DATE] revealed that the resident was a type 2 diabetic and insulin dependent. He was to be offered Glucerna as a meal supplement 2x daily. -The updated care plan dated [DATE] repeated again that the resident was at nutritional risk for weight loss due to dementia. The resident was on a regular diet and had weight fluctuations. No new interventions were documented. -Doctor's orders dated [DATE] included to offer Glucerna 3x times daily. The order also indicated that the resident was to be offered snacks three times daily due to weight loss. Although the daily order for Glucerna was increased, new interventions beyond supplements were not considered. The dietary quarterly assessment dated [DATE] revealed that the resident had a 21% weight loss in the past two months. The assessment indicated that the resident had sporadic meal intakes due to [MEDICAL CONDITION]. None of the care plans and orders referenced above included interventions to address his dementia and what interventions could be considered, given his dementia, to promote weight gain. In addition, there was no evidence the basis for his refusals was investigated by the IDT or NAR committee in order to determine if his refusals could be reversed. Although monitoring of the resident's weight was ordered (see above), there was no evidence the resident's meal intake was monitored and recorded prior to [DATE]. The May record, moreover, revealed orders were not being consistently implemented. Specifically: The nutrition chart for Resident #5 began on [DATE] and ended on [DATE]. It revealed that the resident had eaten ,[DATE]% of 7 meals of the 11 days. He had eaten 26 to 50 % of 8 meals of the 11 days. He ate 75% for 3 meals and had refused to eat 6 of the meals of the 11 days. The nutrition chart revealed that the resident was offered snacks on a daily basis only once a day which the resident refused to eat. b. The resident's weight loss over a period of six months. [DATE] 12:53 144.3 # (from [DATE] to [DATE], a 21% weight loss) [DATE] 13:35 144.8 # [DATE] 14:44 145.2 # (from [DATE] to [DATE], a 9% weight loss) [DATE] 12:43 136.2 # [DATE] 10:58 150.6 # [DATE] 13:14 154.8 # [DATE] 09:25 157.4 # (from [DATE] to [DATE], a 9% weight loss) [DATE] 13:48 168.0 # [DATE] 14:55 164.0 # [DATE] 08:12 166.6 # [DATE] 05:10 170.0 # [DATE] 10:18 171.1 # [DATE] 12:01 174.4 # [DATE] 09:45 175.8 # [DATE] 11:44 174.1 # [DATE] 14:49 173.4 # [DATE] 11:25 172.4 # [DATE] 11:09 175.0 # 3. Observations revealed staff failed to take steps to promote the resident's nutritional status. Staff failed to offer Resident #5 his meal on one occasion, and on another occasion, failed to offer an alternate meal when he refused to eat the meal served. [DATE] (noon meal) -At 12:55 p.m., LPN #1 took food into Resident #5's room. He was asleep and she did not try to wake the resident up for lunch. -At 12:57 p.m., the LPN took the resident's food and left his room. She wrapped the food up and placed it in the refrigerator. She said she would offer it to him later when he woke up. -At 1:35 p.m., Resident # 5 woke up and came out of his room. The LPN did not offer Resident #5 his meal, but rather, gave him a strawberry drink supplement, instead of his meal. He drank 50% of it. Resident #5 was not offered a snack or anything else to eat and at 2:00 p.m., he went down the hall and back to his room. [DATE] -At 4:40 p.m., the dinner meals arrived in the unit. Three minutes later, Resident #5 was observed going down the hall in a wheelchair, asking about dinner. He then returned to his room to eat his dinner. However, after taking two bites of his meal, he refused to eat anymore of his meal, stating the food did not taste good. -At 4:50 p.m., staff picked up the resident's tray. Resident #5 was not offered an alternate meal. 3. Interviews CNA #1 was interviewed on [DATE] at 2:46 p.m. She was familiar with Resident #5. She said Resident #5 needed total assistance for dressing and toileting. She said the resident sometimes had behavior problems and staff had to let the resident cool down before approaching him. She said that Resident #5 was a picky eater. She said Resident #5 would usually drink the supplement the nurses gave him but did not like to sit in his room and eat. She said the resident should be reminded to eat several times during the meal. LPN #1 was interviewed on [DATE] at 3:10 p.m. She said she was familiar with Resident #5. She said Resident #5 suffered from dementia. She said he looked around for his son to come see him. She added that Resident #5 was diabetic. He was prescribed Glucerna three times per day as of [DATE]. She said she tried to offer his meal before he got the supplement. She added he liked ham and cheese sandwiches and she would get one for him when he asked. She said staff let him wake up on his own because he was more cooperative that way. She said his doctor was notified about his weight loss on [DATE] and a physician visit was requested and conducted [DATE]. She said Resident #5 was an independent eater. III. Resident #3 Resident #3, younger than [AGE] years old, was admitted on [DATE]. According to the [DATE] computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. The [DATE] MDS assessment revealed a BIMS score was not conducted. She required supervision set-up for eating. A. Observations Resident #3 was observed during the noon meal on [DATE] at 12:54 p.m. The resident sat on her bed, with the meal tray next to her on the mattress. The resident had consumed approximately 50% of her meal and said the meal was God awful. The resident said she had not been offered an alternative meal. B. Record review 1. Care plan The care plan last revised on [DATE] showed the resident was at nutrition/hydration status as evidenced by [DIAGNOSES REDACTED]. Interventions included: -Encourage good meal intakes and offer substitutes for uneaten food; -Monitor and record all food and fluid intake; -Monitor weight and weight trends per facility protocol; and -Administer supplements as ordered. The care plan had not been updated since the revision date of [DATE]. The care plan did not indicate family and/or the physician were to be notified of any significant weight changes. 2. physician's order [REDACTED]. -Speech therapy (ST) to evaluate the resident for cognition, recent weight loss, poor food intake, environmental changes at meals with a start date [DATE]; and -Registered dietician (RD) to evaluate and treat for protein with a start date of [DATE]. Review of the February 2020 medication administration record (MAR) documented the resident drank 237 milliliters (ml) of the Boost supplement on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and 2/ 23 and eight ml on ,[DATE]. The MAR indicated the resident refused the supplement 18 days during the month of February. The remaining three days in the month of February documented either the supplement was given without the quantity documented or ' other/see progress notes ' was indicated; however, review of the progress notes for the remaining days did not reveal a progress note of refusal by the resident and/or an explanation as to why the supplement was not consumed. Review of the [DATE] MAR documented the resident drank 237 ml of the Boost supplement on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and ,[DATE] and 120 ml on ,[DATE] and ,[DATE]. The remaining 19 days in the month of February documented either the supplement was given without the quantity documented or the resident refused the Boost supplement. Review of the progress notes revealed there was no indication that the resident was offered and refused the supplement. Review of the [DATE] MAR documented the resident drank 236 ml of the Boost supplement on ,[DATE], ,[DATE], ,[DATE], and ,[DATE]. The MAR indicated the resident refused the supplement four times during the month on ,[DATE], ,[DATE], ,[DATE], and ,[DATE]. The remaining 22 days in the month of April documented ' other/see progress notes ' ; however, review of the

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 3) progress notes for the remaining days did not reveal a progress note of refusal by the resident and/or an explanation as to why the supplement was not consumed. The DON was interviewed on [DATE] at 4:30 p.m. The DON said when the MAR showed other/see progress notes, that meant a progress note needed to show a note to indicate the reason the Boost was not consumed. The medical record failed to show any progress notes in regards to the refusal of the Boost supplement. Furthermore, there were no notes to indicate that the RD and physician were notified of the refusal and no evidence staff investigated the resident ' s refusals or offered a different type of supplement in order to encourage intake. 3. Weight loss The resident matrix provided by the DON on [DATE] at 12:17 p.m., showed Resident #3 had excessive weight loss without a prescribed weight loss program. Review of the medical record revealed the resident had a severe weight loss at 22.41% over a six month period between [DATE] and [DATE]. The weights were as follows: -[DATE]: weight of 110.8 pounds (21.97% weight loss x one month; 22.41% weight loss x six months) -[DATE]: weight of 110.4 pounds (22.25% weight loss x one month; 22.69% weight loss x six months) -[DATE]: weight of 119 pounds (16.2% weight loss less than one month; 12.76% weight loss x six months) -[DATE]: weight of 142 pounds -[DATE]: weight of 134 pounds -[DATE]: weight 135 pounds -[DATE]: weight of 124.5 pounds -[DATE]: weight of 127.8 pounds -[DATE]: weight of 132.4 pounds -[DATE]: weight of 142.8 pounds -[DATE]: weight of 136.4 pounds -[DATE]: weight of 130 pounds There was no record of the resident being reweighed or a progress note added to the residents medical record, as outlined in the Weight Pathway Policy, when there was a discrepancy of +/- three pounds from the prior documented weight. The most recent dietary quarterly assessment dated [DATE] was reviewed. It revealed .The resident tolerated a regular diet with a food intake of ,[DATE]%. The resident was provided supplements of boost, [MEDICATION NAME] (vitamin D), and potassium and would be provided with fortified foods. Current body weight was 132.4 lbs on [DATE] with a body mass index (BMI) of 19.5. The residents ideal body weight was 135 lbs. The assessment indicated the resident had a significant weight change quantified as >5% x one month, >7.5% x three months, >10% x 180 days. Resident was seen by ST recently and noted the resident needed to be cued for meals and encourage to sit at table for increased intake. IDT interventions included weekly weights on resident x4 weeks . Review of the [DATE] CPO did not reveal weekly weights had been ordered nor were they documented on the medication administration record (MAR) or treatment administration record (TAR). The interdisciplinary team (IDT) note for weight and skin, completed by the dietary manager (DM) on [DATE] revealed the residents previous weight was 143 lbs on [DATE] and her current weight was 132.4 lbs on [DATE]. The IDT note documented there was not a need to reweigh the resident, even though the Weight Pathway Policy indicated a resident should be reweighed if there was +/- three pounds from the previous weight. The IDT note documented the resident was triggered for weight loss and will monitor for three more weeks or until stable. Review of the medical record did not reveal documentation for food or fluid intakes for the resident from February 2020 to [DATE]. The DON was interviewed on [DATE] at approximately 11:00 a.m. The DON said she was unable to provide copies of the meal intakes for Resident #3 for the months of February 2020 though [DATE], as they were not completed. She said she had now provided training to the staff to record food intake. Review of the progress notes revealed: -[DATE] Weight Change Note: .WEIGHT WARNING: Value: 130.0 .Vital Date: [DATE] .-5.0% change (13.9% , 21.0), -7.5% change (13.3% , 20.0), -10.0% change (10.3% , 15.0); Reweigh requested. Continues to come to the main dining room (MDR) for meals. Appears at her baseline. No other significant changes observed . -[DATE] nurse practitioner (NP): .The patient was seen for abnormal weight loss. Her weight is down to 136.4 lbs. She is on a regular diet. Staff report she is eating and drinking. She was seen by dietary. She is on a supplement. Abnormal weight loss recurrent. Continue to monitor. RD to continue to follow. Continue supplement. Follow-up next month . -[DATE] dietary: .Quarterly assessment: Resident continues a regular diet with regular texture and thin liquids .has a history of variable weights, which may be related to her mood she has had some weight variance that has somewhat recovered in December .resident can and does express her food preferences .she attends meals in the dining room .she appears at her baseline, no temporal wasting or distended collar bones observed .was recently ordered Boost daily for weight loss .current intake of >50% of most meals .no new recommendations at this time .continue to monitor per facility protocol . -[DATE] MedB Note Late Entry: .resident on ST for cognition and diet, continues . -[DATE] nursing: Resident usually refuses weights x2 at different times throughout the day. Resident educated about importance of weights to maintain health status. Will continue to attempt to get weights on resident although she has continued to refuse weights. -[DATE] MedB Note Late Entry: .Resident on ST for cognition and diet, continues . -[DATE] MedB Note Late Entry: .Resident on
F 0802 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.** Based on observations, staff interviews and record review, the facility failed to employ sufficient dietary support staff to carry out the functions of the food and nutrition services department in one of one facility kitchens. Specifically, the facility failed to ensure: -The dietary department had sufficient numbers of adequately trained food and nutrition staff to ensure safe and sanitary food service; and -The dietary department had sufficient staff to ensure the meals were prepared and served according to the posted meal times. Cross-reference F812, kitchen sanitation and F809 frequency of meals Findings include: I. Dish machine A. Observations The facility kitchen was toured on 5/28/2020 beginning at 11:15 a.m. There were incomplete dish machine temperature and sanitizer concentration level logs. The last time the dish machine was monitored and checked for proper sanitation by staff was 2/3/2020. The plaque on the dishmachine documented the bleach level was 50 parts per million which indicated it was a low temperature machine. Interview The dietary aide (DA) #1 was interviewed on 5/28/2020 at approximately 11:30 a.m. The DA #1 said the dishmachine was a high temperature machine, as the water was very hot. The dietary manager (DM) was interviewed on 5/28/2020 at approximately 11:30 a.m. The DM said the dishmachine was a high temperature machine. Observations On 5/28/2020 at approximately 11:53 a.m., the DA #1 was observed to be washing dishes. The DA was observed to touch dirty dishes, then immediately go to the clean dishes and remove them from the dishmachine. She did not wash her hands or change gloves in between clean and dirty. On 6/1/2020 at 12:15 p.m., the admission coordinator (AC)was observed to put a pan into the dishmachine, and immediately removed dishes from the clean side. She did no handwashing between dirty to clean. Interview DA #1 was interviewed on 5/2/2020 at approximately 12:00 p.m. The DA said she was not trained on the proper way to wash dishes. She said that approximately three months ago, the dish washer quit, and so she was then put into the position. She said she had not been trained on the type of dishmachine, or to check the sanitizer, temperature, or about cross contamination. The AC was interviewed on 6/1/2020 at approximately 12:20 p.m. The AD said she occasionally helps in the kitchen. She said she was trained how to turn on the dish machine, however she was not trained on how to properly wash dishes. She did not know that she needed to wash her hands between dirty and clean dishes. II. Late meals A. Posted meal times The posted dining room meal times were: 7:30 a.m. Breakfast 12:30 a.m. Lunch 5:30 p.m. Dinner The DM was interviewed on 5/28/2020 at 11:25 a.m. The DM said the residents were all being served meals in their rooms due to the COVID 19. He said the room trays began at 12:00 p.m, to be served and to the units by 12:30 p.m. B. Late meals Resident Interview Resident #6 was interviewed on 5/28/2020 at 11:40 a.m. Resident #6 who said he also held the position of the resident council president, said the meals were consistently late. C. Observation On 5/28/2020 the noon meal service was observed beginning at 11:15 a.m., the kitchen had three staff members working. -At 12:15 p.m., the DM continued to prepare the meal. -At 12:15 p.m., the DA #2 was cutting the tomatoes which were to be served with the hamburgers -At 12:21 p.m., the DM was cutting the lettuce which was to be served with the hamburgers. There was no food on the steam table. The meal was to be completed and served and on the units by 12:30 p.m. However, the food continued to be prepared. -At 12:27 p.m., the DM was cutting the onions for the hamburgers -At 12:32 p.m, the DM was preparing the mixed vegetables to serve with meal. -At 1:13 p.m., the second food cart continued to be prepared for the units. -At 1:23 p.m., the last tray was prepared and the second cart was completed and ready to be transported to the unit nearly one hour after the posted meal time. 6/1/2020 Noon meal -At 12:50 p.m., the trays went to the unit from the kitchen. D. Interview The DM was interviewed on 5/28/2020 at approximately 11:30 a.m. The DM said that at present time he was short of staff. He said the hours had to be adjusted in the kitchen as he was the only cook. He had two DAs. He said that they leave at approximately 4:30 p.m., and return in the morning at approximately 6:30 a.m. The DA #1 was interviewed on 5/28/2020 at approximately 12:00 p.m. She said when she came to work in the morning her primary job was to start with the dishes. As all of the dinner dishes from the night before were stacked outside the kitchen, and she needed to get them washed prior to the breakfast service. The dietary manager (DM) was interviewed on 6/1/2020 at approximately 11:30 a.m. The DM said the breakfast was dished up onto the plates and placed into the food carts at 8:00 a.m. He said the carts were then pushed to the units by 8:30 a.m. He said because of the staffing shortage, the hours of the meals were adjusted. The

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	065285	A. BUILDING _____ B. WING _____	06/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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F 0802 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) director of nurses (DON) was interviewed on 6/1/2020 at 3:05 p.m. The DON confirmed the noon meal was served late. The nursing home administer (NHA) was interviewed on 6/3/2020 at approximately 11:45 a.m. The NHA said he was not aware of the plan that the meals were served outside of the posted meal times. However, the NHA was observed to serve the meals to the residents during the observations.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observations, record review and interviews, the facility failed to meet the nutritional needs of the residents in accordance with established national guidelines in one of one serving units. Specifically, the facility failed to: -Follow the menu approved by a registered dietitian (RD); -Follow the menu extensions that included what was to be served and the portion sizes; -Follow standardized recipes that corresponded to the menu; and -Provide a variety of vegetable sides on the menu. Cross reference F692 Nutrition and Hydration Findings include: I. Menu extensions and serving sizes not being followed. Observations during the survey revealed concerns with small portions being served and menu items being omitted without substitutions being made. The menu was not approved by an RD to ensure it met the resident ' s daily nutritional requirements. 1. Noon meal 5/28/2020 The menu which the DM used documented: Week 4- cheese burger, macaroni and cheese, assorted vegetables, dinner roll and yogurt and berries. -The regular diet received a hamburger on a bun, #10 (3.2 oz) scoop of coleslaw, french fries- which were not measured, lettuce, tomato and onion, and a piece of cake. -The mechanical soft diet received a ground hamburger patty on a bun, french fries, mixed vegetables which contained broccoli, cauliflower, carrots, green beans and a piece of cake. -The puree diet received a puree hamburger and bun made with water, pureed vegetables and a piece of cake. 2. Noon meal 6/1/2020 The menu which the DM used documented, Week 5, German shepherd ' s pie, dinner roll and brownie. -The regular and mechanical soft diet received one #8 scoop (4 oz) of shepherd ' s pie, dinner roll and a brownie. -The puree diet received a #8 scoop (4 oz) of the shepherd's pie, a pureed dinner roll, and a brownie that was pureed with water. 3. Dinner meal on 6/2/2020 The menu which the DM used documented, Week 5 chicken and dumplings, mixed vegetables, dinner roll and white cake. -The regular and mechanical soft diet received a #8 scoop (4 oz) of chicken and dumplings which contained carrots and green beans, mixed vegetables that consisted of broccoli, french fries, cauliflower, carrots and green beans. A slotted spoon was used to serve the chicken dumplings and mixed vegetables. 4. Noon meal 6/3/2020 The menu which the DM used documented, Week 5 Goulash, Italian blend vegetables- broccoli, cauliflower, carrots, bread stick and a cookie. The DM was interviewed on 6/3/2020 at approximetly 11:15 a.m. The DM said beef goulash, Italian blend vegetables- broccoli, cauliflower, carrots, bread stick and a cookie were being served. B. Staff interview The DM was interviewed on 5/28/2020 at p.m. The DM said the menus which he used did not have extensions. II. Follow standardized recipes that correspond to the menu. A. Noon meal 6/1/2020 The DM was observed to place three pieces of brownie into the food processor. The DM then added eight oz of water to the brownie. The DM was interviewed on 5/28/2020 at approximately 4:30 p.m. The DM said he did not have any recipes to use. He said he had cooked for years. The DM was interviewed on 6/1/2020 at 4:30 p.m. The DM said he did not have a recipe to follow when he made the brownie or any of the puree meals. The DM said he did not have a recipe for the shepherd ' s pie. He said he used two chubs of hamburger (10 pounds a piece), two bags (4 lbs each) of mixed vegetables, one #10 (6 lbs and 6 oz) can of tomatoes and one full instant potato container. The container was for 142 servings. The DM said he cooks for 52 residents. The DM was interviewed on 6/3/2020 at approximately 11:00 a.m. The DM said he did not have a recipe for the Goulash which was on the menu for the noon meal served that day. III. Provided a variety of vegetable sides on the menu. A. Resident interviews Resident #7 was interviewed on 5/28/2020 at 11:36 a.m. The resident said there were a lot of repeats with the vegetables offered on the menu. Resident #11 was interviewed on 5/28/2020 at 11:38 a.m. The resident said that she received a lot of broccoli and cauliflower. Resident #6 was interviewed on 5/28/2020 at 11:40 a.m. The resident said there were repeats when it came to the vegetables. He said there were a lot of mixed vegetables with carrots and broccoli. B. Noon meal 5/28/2020 The mechanical soft and pureed diet received mixed vegetables which contained broccoli, french fries, cauliflower, carrots and green beans. C. Dinner meal 6/2/2020 The regular, mechanical soft and pureed diet all received mixed vegetables which contained broccoli, french fries, cauliflower, carrots and green beans. D. Noon meal 6/3/2020 The regular, mechanical soft and pureed diet all received a mixed Italian blend vegetables- broccoli, cauliflower, carrots. Interviews The registered dietitian (RD) was interviewed on 6/3/2020 at 9:30 a.m. The RD said her contract with the facility started in May 2020. She said she was not aware the kitchen was not using menu extensions or recipes. She said menus needed to followed and a standardized recipe as part of a planned menu and reviewed by an RD to ensure it was meeting their daily nutrition needs and not having the scoop size to be served/amount. She said the facility sent her menus, which were the Shamrock menus. The nursing home administrator (NHA) was interviewed on 6/3/2020 at 11:45 a.m. The NHA said the menus which the dietary manager was to be using the Shamrock menus. He said the dietary manager had been trained on the system and how to utilize the menus. He said he was not aware the appropriate menu was not being followed. The NHA said he would provide the training that the DM went through. However, at the completion of the survey on 6/5/2020, the training was not received, and it was requested on 6/4/2020 at 4:30 p.m., and again on 6/5/2020 at approximately 11:00 a.m. The DM was interviewed on 6/3/2020 at approximately 1:00 p.m. The DM said he had not been trained on the Shamrock menus, and that he was using the menus the prior DM directed him to use.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews; the facility failed to provide food that accommodated resident allergies [REDACTED].#1, #2, #5 #6, #7, #8, #10, #11, #12) out of 12 total sample residents. Specifically the facility failed to: -Offer food choices to residents who requested options or a different meal choice. -Provide menus to the residents on a regular basis. Findings include: A. Observations The facility had no posting of the menu On 5/28/2020 the noon kitchen tray line was observed. The trays were prepared using a resident list, which had the prescribed diet. Otherwise there was nothing which indicated the residents likes and dislikes. There was no meal questionnaire which indicated what the resident wanted to eat for the meal. On 5/28/2020 at 1:35 p.m. Resident #1 was asleep in her wheelchair. Her lunch was sitting on the table in front of her. She never ate lunch. At 1:37 p.m Resident #1 was not offered an alternative meal. On 6/1/2020 at approximately 12:00 p.m., Resident # 11 asked for pizza. The medical records coordinator told her she did not know what was being served. She then walked away from the resident. The resident was served her meal, of [MEDICATION NAME] pie. The resident said she did not want it, she wanted pizza. She was provided a ham sandwich instead. On 6/1/2020 at 1:17 p.m. the resident in room [ROOM NUMBER] received her lunch from the director of nursing(DON.) The resident refused the lunch meal and the DON did not offer the resident an alternative. On 6/1/2020 at 1:31 p.m., Resident #2 had not eaten his meal, and prior to his tray being removed by licensed practical nurse #1 (LPN) she did not not offer the resident any alternative food options. He had eaten approximately 10 percent of his meal. On 6/1/2020 at 4:48 p.m. Resident #5 took two bites of his dinner meal then refused to eat. He said the food did not taste good. He was not offered an alternative meal. B. Resident interviews Resident #7 was interviewed on 5/28/2020 at 11:36 a.m. The resident prior to COVID 19 the residents were provided a menu and the choice of what they wanted to eat. She said that was no longer. She said she would like to have the choice of what she wanted to eat. Resident #11 was interviewed on 5/38/2020 at 11:37 a.m. The resident said she was not provided a choice on what she wanted to eat. She said that she did not know what was being served as there was no menu posted. Resident #6 was interviewed on 5/28/2020 at 11:40 a.m. The Resident #6 said he did not receive a choice on what he wanted to eat. He said the administration had told him about always available menu, however, it was not honored when he asked for it. He said he would like to know what was being served. Resident #10 was interviewed on 6/1/2020 at 1:30 p.m., she said that this was not the first time they have ran out of food. She said that by the time they get to her room which is at the end of the hall, they have no more food. She said she did not receive the brownie as they ran out of it. She said she was looking forward to the brownie. Resident #8 was interviewed on 5/28/2020 at 2:00 p.m. She

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F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) said food preferences were not honored. She said she was was a diabetic and she was not getting the special foods she requested from the kitchen. Resident #12 was interviewed on 6/3/2020 at approximately 1:30 p.m. The resident said for breakfast he filled out a request form to receive three fried eggs, two pieces of bacon and toast. He said instead he received one scrambled egg, a sausage link, and toast and oatmeal. C. Record review The preference form showed for breakfast eggs, sausage, bacon, hot cereal, cold cereal pancake and toast was available. Lunch and dinner showed soup, chef salad, cottage cheese, fresh fruit, turkey sandwich, ham sandwich, hamburger, hot dog and chips. The form document to check items which were requested and submit two hours prior to the meal. D.Resident council minutes The food committee notes dated 4/30/2020 included the residents had requested menus before the meals.The residents also asked for an alternative meal if the meal being served was not suitable for them.The notes revealed the residents wanted to be served their food on time.They were tired of getting their food late and cold. The food committee notes on 5/26/2020 requested for the residents to be offered alternative choices at meal times.The resident asked for a bigger variety of snacks to be offered at snack time.Two suggestions were fresh fruit and fresh vegetables.The residents had requested for the meals to be served on time E. Interviews The dietary aide (DA #1) was interviewed on 5/28/2020 at approximately 12:30 p.m. The DA said the resident list with the prescribed diet was used. She said meal cards were not used, that she would wrap the dish in plastic wrap and then write the resident name on the plastic wrap. She said since the COVID 19 began then they did not receive anymore of the preferences. The dietary manager was interviewed on 5/28/2020 at approximately 12:30 p.m. The DM said there was an always available menu such as a chef salad, soup, and sandwiches. He said Resident #8 always wanted a hamburger at the dinner meal, so he would send a hamburger automatically. He confirmed the preference forms were not used. Licensed practical nurse (LPN #1) was interviewed on 6/1/2020 at 3:05 p.m. The LPN said prior to the COVID 19 the certified nurse aides would ask what the resident what they wanted to eat prior to the meal. The forms were filled out and returned to the kitchen. However, now that process had stopped. She said menu cards with likes and dislikes were not used. F. Follow- up On 6/5/2020 at 10:45 a.m., the menu was posted in the hallway.
F 0809 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility failed to ensure residents received their meals in a timely manner and the facility failed to have substantial nursing snack available. Specifically, the facility failed to ensure: -There were not more than 14 hours between a substantial evening meal and breakfast the following day; -The residents did not have prolonged wait times of 30 minutes or longer for their meal to be served; and -To offer nourishing snacks at bedtime to residents. Findings include: I. Snacks available A. Observations 5/28/2020 -At 11:27 a.m., the nourishment refrigerator was was observed. The refrigerator had a pad lock on the refrigerator and a combination lock on the freezer. The key to the lock was stored near the nurses desk. Licensed practical nurse #1 opened the refrigerator. It contained a pitcher of orange juice, a gallon of milk and a few individual bottles of glucerna. The refrigerator contained no snacks. The freezer had no snacks or food to consume. -At 4:30 p.m., the kitchen dietary assistant (DA#1) prepared the snacks for the residents. The snacks were on a cart, being ready to be delivered to the nourishment refrigerator. There were five sandwiches, three fudge bars, 10 oatmeal cream cookies, nine bags of individual potato chips, 15 graham crackers, six chocolate chip cookies and nine nutter butters. The snacks which were to be delivered to the nourishment refrigerator did not have any for the residents who required puree consistency. -At 5:00 p.m., LPN #1 unblocked the refrigerator. The nourishment refrigerator contained five sandwiches, six bags of chips and 7 bags of cookies. It also contained supplement drinks. B. Interviews The LPN #1 was interviewed on 5/28/2020 at 11:30 a.m. The LPN said the refrigerator was locked as their were some residents who would eat everything in the refrigerator if it was left unlocked. The DA #1 was interviewed on 5/28/2020 at 4:30 p.m. The DA said she prepared the snacks before she left for the night. She said that she had five sandwiches and then the other ready prepared snacks. The sandwiches were ham and two were peanut butter and jelly. C. Resident Interviews Resident #7 was interviewed on 5/28/2020 at 11:36 a.m. The resident said snacks were not always available. She said she had to ask for snacks, and they were not offered. Resident #6 was interviewed on 5/28/2020 at 11:40 a.m. The Resident #6 said snacks were not always available. He said that he purchases his own snacks, so that way to ensure he had a snack. II. Meals served greater than 16 hours A. Posted meal times The posted dining room meal times were: 7:30 a.m. Breakfast 12:30 a.m. Lunch 5:30 p.m. Dinner The DM was interviewed on 5/28/2020 at 11:25 a.m. The DM said the residents were all being served meals in their rooms due to the COVID 19. He said the room trays began at 12:00 p.m, to be served. B. Resident interviews Resident #6 was interviewed on 5/28/2020 at 11:40 a.m. The resident who was the resident council president said, meals were served late. He said the breakfast meal was often served as late as 9:30 a.m. He said the lunch was served at 1:30 or later, then the dinner meal was served beginning at 4:00 p.m. Resident #8 was interviewed on 5/28/2020 at 2:00 p.m. She said her lunch was served cold today. Resident #8 said the facility never had enough CNA ' s often had to wait a long time to get their food served to them. She said the food was that the meals were late on most days. Resident #7 was interviewed on 5/28/2020 at 3:40 p.m. The resident said that dinner was served at 4:30 p.m. and breakfast was served as late as 9:30 a.m. She said she had to ask for snacks, and they were not offered. Resident #9 was interviewed on 5/28/2020 at 3:50 p.m. The resident said that breakfast was served sometimes as late as 9:30 a.m. She said dinner was served at 4:30 p.m., and on some days it was served after six. She said the meal times were random and did not follow the posted meal times. B. Observations 5/28/2020 Noon meal -At 1:00 p.m., one of two food carts was brought to the unit. -At 1:05 p.m., the staff began passing the food to the residents in their rooms -At 1:10 p.m. the resident in room [ROOM NUMBER] received her lunch. -At 1:20 p.m.Resident #2 called out to the staff for his lunch from the end of Oak hall. -At 1:30 p.m. Resident #1 received her lunch. -At 1:40 p.m. Resident #2 received his lunch in his room. 6/1/2020 Noon meal -At 12:50 p.m The lunch meal arrived in the unit. -At 1:06 p.m. Resident #1 received her food. -At 1:17 p.m. the resident in room [ROOM NUMBER] received her lunch from the director of nursing(DON.) 6/1/2020 Evening meal -At 4:45 p.m. the meal trays were being passed out. 6/2/2020 Evening meal -At 4:50 p.m., the meal trays were being passed to residents. 6/3/2020 Breakfast meal -At 8:46 a.m., breakfast was being served to the residents. C. Interviews The dietary manager (DM) was interviewed on 6/1/2020 at 4:38 p.m. The DM said the breakfast was dished up onto the plates and placed into the food carts at 8:00 a.m. He said the carts were then pushed to the units by 8:30 a.m. He said because of the staffing shortage, the hours of the meals were adjusted. He said they finish in the kitchen and are done for the day by 4:30 p.m. He said the heated meal carts were parked in the employee break room until the certified nurse aides were ready to pass them out. The two heated meal carts were observed with the DM to be parked in the employee break room. Certified nurse aide #2 (CNA#2) was interviewed on 6/3/2020 at 3:00 p.m. She said the meal times for residents were sporadic.The breakfast was served anywhere from 8:30 a.m. to 9:30 a.m.The lunch came out between 12:30 and 1:30 p.m.The dinner meal was scheduled at 5:30 p.m. but they often served the residents between 4:30 p.m. and 5:00 p.m. There was 16 hours in between the supper meal and the breakfast meal the next day. The nursing home administer (NHA) was interviewed on 6/3/2020 at approximately 11:45 a.m. The NHA said the snacks should meet the needs of the residents. He said that a substantial snack would be something like cottage cheese, yogurt and peanut butter sandwiches. He said he was not aware of the lack of snacks for the residents. He said he was not aware of the plan that the meals were served outside of the posted meal times. Although the NHA said he was not aware of the meals being served outside of the posted meal times, he was observed to pass the trays to the residents at each of the meals observed. He included he was not aware that there was more than a 16 hour gap between dinner and breakfast. He said the meal times would be adjusted right away.
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.**

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	065285	A. BUILDING _____ B. WING _____	06/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to ensure the dietary department followed safe practices to prevent the potential contamination of food and the spread of food-borne illness. The following sanitation concerns were found: -Holding temperatures were not at appropriate level; -Hand washing sink was dirty; -Expired food not dated, labeled, and disposed of in a timely manner; -Moisture was between stacked pans; -Chemicals left next to food; -Knowledge of the dish machine; -Appropriate use of gloves when handling ready-to-eat foods; and -Meat was left on the counter; -Can opener was dirty; Findings include: I. Holding temperatures were not at appropriate level A. Professional reference The Food and Drug Administration (FDA) Food Code (2019) p. 441, When food is held, cooled, and reheated in a food establishment, there is an increased risk from contamination caused by personnel, equipment, procedures, or other factors. If food is held at improper temperatures for enough time, pathogens have the opportunity to multiply to dangerous numbers. Proper reheating provides a major degree of assurance that pathogens will be eliminated. It is especially effective in reducing the numbers of ,[MEDICAL CONDITION]. perfringens (C. perfringens) that may grow in meat, poultry, or gravy if these products were improperly cooled. Vegetative cells of C. perfringens can cause foodborne illness when they grow to high numbers. Highly resistant C. perfringens spores will survive cooking and hot holding. If food is abused by being held at improper holding temperatures or improperly cooled, spores can germinate to become rapidly multiplying vegetative cells. -The Colorado Department of Public Health and Environment (2019) The Colorado Retail FoodEstablishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR _RFFC_EffJan2019.pdf. It read in pertinent part; The food shall have an initial temperature of 41F or less when removed from cold holding temperature control or 135F or greater when removed from hot holding temperature control. B. Observations On [DATE] at 12:40 p.m., the meal was observed to be served, but food temperatures were not taken before the meal was served. At 12:57 p.m., the DM took the temperature of the coleslaw, which was in a large pan. It revealed a temperature of 48.2 degrees Fahrenheit (F). The thermometer used by the DM was not working and he used the surveyors thermometer. He said he had another thermometer in the office. On [DATE] at approximately 12:00 p.m.,, the DM took the temperature of the food; however, he did not take the temperature of the puree meal. The meal consisted of dumplings that contained green beans and carrots and mixed vegetables that contained broccoli and cauliflower, as well as green beans and carrots. C. interviews The DM was interviewed on [DATE] at approximately 10:30 a.m. The DM said the holding temperature for cold foods should be at 41 degrees F and below and the hot foods should be held between 145 and 165 degrees F. I. Moisture in pans A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail FoodEstablishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR _RFFC_EffJan2019.pdf. It read in pertinent part; . Unless used immediately after sanitization, all equipment and utensils shall be air-dried. Towel drying shall not be permitted. Utensils that have been air-dried may be polished with cloths which are maintained clean and dry . B. Observations On [DATE] at 11:15 a.m., moisture was observed between pans stacked three high for half sized pans and three high for quarter sized pans. On [DATE] at 11:00 a.m., with the dietary manager, the pans were observed to be stacked three high for half pan and three high for quarter size pans. Moisture was observed between the pans. Staff interviews The dietary manager (DM) was interviewed on [DATE] at 11:00 a.m. He said the pans should not be stacked when they were wet. He said the pans needed to be air dried before they were stacked. He acknowledged there was water between the pans. II. Chemicals stored next to food A. Professional reference The Colorado Retail Food Establishment Rules and Regulations (CRFERR), revised [DATE], read in pertinent part, .Containers of chemical sanitizing solutions specified in which wet wiping cloths are held between uses shall be stored off the floor and used in a manner that prevents contamination of food, equipment, utensils, linens, single-service, or single-use articles .single-use disposable sanitizer wipes shall be used in accordance with EPA-approved manufacturer ' s label use instructions .Cloths in-use for wiping surfaces in contact with raw animal foods shall be kept separate from foods . B. Observations On [DATE] at 12:02 p.m., observed two bottles of vinegar and two bottles of white cooking wine on a bottom shelf next to the stove. There were two spray bottles of grill cleaner on the same shelf, one next to the vinegar and one next to the white cooking wine. C. Staff interviews The DM was interviewed on [DATE] at 12:08 p.m. He was shown the bottles of the grill cleaner next to the vinegar and white cooking wine. He said the vinegar and the white cooking wine were used for cooking. He said the chemicals were supposed to be stored in the closet with all of the other chemicals. The DM removed the chemicals from the shelf. The DM was interviewed a second time on [DATE] at approximately 3:00 p.m. The DM said he told the staff not to store chemicals next to the food, but he did not do a formal training. The DM was interviewed a third time on [DATE] at 11:00 a.m. He said that he expected the staff to not put the chemicals next to the food, but he had not provided training to the staff. He said the chemicals needed to be stored in the closet. III. Moisture in pans A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail FoodEstablishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR _RFFC_EffJan2019.pdf. It read in pertinent part; . Unless used immediately after sanitization, all equipment and utensils shall be air-dried. Towel drying shall not be permitted. Utensils that have been air-dried may be polished with cloths which are maintained clean and dry . B. Observations On [DATE] at 11:15 a.m., moisture was observed between pans stacked three high for half sized pans and three high for quarter sized pans. On [DATE] at 11:00 a.m., with the dietary manager, the pans were observed to be stacked three high for half pan and three high for quarter size pans. Moisture was observed between the pans. Staff interviews The dietary manager (DM) was interviewed on [DATE] at 11:00 a.m. He said the pans should not be stacked when they were wet. He said the pans needed to be air dried before they were stacked. He acknowledged there was water between the pans. IV. Hand washing sink was dirty A. Professional reference The Food and Drug Administration (FDA) Food Code (2019) p. 393, 522 .Effective handwashing is essential for minimizing the likelihood of the hands becoming a vehicle of cross contamination. It is important that handwashing be done only at a properly equipped handwashing facility in order to help ensure that food employees effectively clean their hands. Handwashing sinks are to be conveniently located, always accessible for handwashing, maintained so they provide proper water temperatures and pressure, and equipped with suitable hand cleansers, nail brushes, and disposable towels and waste containers, or hand dryers .A handwashing sink that is properly located is one that is available to food employees who are working in food preparation, food dispensing, and warewashing areas. Handwashing sinks that are blocked by portable equipment or stacked full of soiled utensils and other items, are rendered unavailable for employee use. Nothing must block the approach to a handwashing sink thereby discouraging its use, plus it must be kept clean and well stocked with soap and sanitary towels to facilitate frequent use . B. Observations On [DATE] at 11:15 a.m., the hand washing sink was observed with visible dirt and required cleaning. On [DATE] at 11:45 a.m., the hand washing sink was observed with visible dirt and needed to be cleaned. On [DATE] at 4:01 p.m., the hand washing sink was observed with visible dirt and needed to be cleaned. The nurse consultant was in the kitchen, and he was shown the sink. At approximately 4:30 p.m., the nurse consultant said he had washed the sink. C. Interview The DM was interviewed on [DATE] at 11:00 a.m. The DM said the hand washing sink needed to be cleaned daily. V. Appropriate use of gloves when handling ready-to-eat foods A. Professional reference -The FDA Food Code (2017) p.11, defines a highly susceptible population (HSP) as: Persons who are more likely than other people in the general population to experience foodborne disease because they are .immunocompromised or older adults .or persons who obtain food at a facility that provides services such as custodial care, health care, or assisted living .such as a nursing home. -According to the FDA Food Code (2017) p. 24, A utensil was defined as a food contact implement or container used in the storage, preparation, transportation, dispensing, sale, or service of food, such as kitchenware or single-use gloves used in contact with food. -The Colorado Retail Food Establishment Rules and Regulations (CRFERR), revised [DATE], read in pertinent part, .Employees prevent bare hand contact with ready-to-eat food by properly using suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. If used, single-use gloves shall be used for only one task, such as working with ready-to-eat food. Single-use gloves shall be used for no other purpose, and discarded when damaged, when interruptions occur in the operation, or when the task is completed. 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 before handling or putting on single-use gloves for working with food, and between removing soiled gloves and putting on clean gloves . -The Food and Drug Administration (FDA) Food Code (2019) pp. ,[DATE], detailed the following instances when foodservice staff should wash their hands: -Immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service articles and single-use articles; -After touching bare human body parts other than clean hands and clean, exposed portions

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7) of arms; -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; and -After engaging in other activities that contaminate the hands. B. Observations On [DATE], the following observations were made of the noon meal: -At 12:57 p.m., the noon meal continued. The dietary aide (DA) #2) did not use any utensils and touched the buns with his gloved hands. The DM, with his gloved hand, placed the hamburger patty on the bottom bun and then placed the top bun onto the hamburger patty. The DM touched spoons, which were handled without gloves prior to the service, and the DA handled the onion and tomato tongs. The certified nurse aide (CNA) #4 was observed on [DATE] at 12:56 p.m., to cut the sandwich for Resident #11. As she cut the sandwich she placed her bare hand over the top of the sandwich as she cut it. C. Staff interview The CNA #4 was interviewed on [DATE] at 12:58 p.m. CNA #4 said she was sorry for cutting the sandwich with her bare hands, and that she knew she needed to use gloves or utensils. VI. Meat was left on the counter A. Professional reference -The Food and Drug Administration (FDA) Food Code (2019) pp. ,[DATE] detailed the following instances for proper thawing of foods: - Under refrigeration that maintains the food temperature at 5oC (41oF) or less; -Completely submerged under running water: (1) At a water temperature of 21oC (70oF) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (3) For a period of time that does not allow thawed portions of ready-to-eat food to rise above 5oC (41oF), or (4) For a period of time that does not allow thawed portions of a raw animal food requiring cooking to be above 5oC (41oF), for more than 4 hours including: (a) The time the food is exposed to the running water and the time needed for preparation for cooking, or (b) The time it takes under refrigeration to lower the food temperature to 5oC (41oF); - Thawed in a microwave oven and immediately transferred to conventional cooking equipment, with no interruption in the process. B. Observations On [DATE] at 11:25 a.m., a full sheet pan containing frozen hamburger patties was left on the preparation table to thaw. At 11:46 a.m., the full sheet pan of meat was still on the preparation counter. At 11:50 a.m., the full sheet pan of meat was still on the preparation counter. At 12:02 p m., the DM put the full sheet pan of meat into the oven. He removed two sheet pans from the oven and placed the patties in a pan on the stove filled with beef broth. The DM said he could not get all the pans in at once and therefore it had to sit out on the counter until it was time to put it into the oven. He said the pattys started out frozen. When he put the pattys (cooked) ones into the pan he did not take the temperature, he said they will continue to cook in the boiling beef broth. VII. Expired food not dated, labeled, and disposed of in a timely manner A. Professional reference -The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR _RFFC_EffJan2019.pdf. It read in pertinent part, Except when packaged food using a reduced oxygen packaging method, Time/Temperature control for safety of food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41F (farenheit) or less for a maximum of seven days. The day of preparation shall be counted as day one. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. -According to the Colorado Retail Food Establishment Rules and Regulations (effective [DATE]) pg. 92 .all ready to eat, time/temperature control for safety food (TCS) served in facilities providing food to highly susceptible populations shall be clearly marked to indicate the date the food should be consumed or discarded .the day the original container is opened shall be counted as day one (1) . -According to the Food and Drug Administration (FDA) 2017 Food Code, pp. ,[DATE], .except during preparation, cooking, or cooling, or when time is used as the public health control, cold foods should be kept at 41 degrees Fahrenheit (F) or less . B. Observations The kitchen was observed on [DATE] at 11:15 a.m. and revealed the following: -There was not a thermometer in the walk in refrigerator; -The bacon had an expiration date of [DATE]; -The applesauce was dated [DATE]; -The oatmeal was dated [DATE]; -Jelly had been poured from its original container into a clear, undated container; -Unidentified food was in a clear container dated [DATE]. C. Staff interviews The DM was interviewed on [DATE] at 12:25 p.m., he said all foods should be dated. He said at the time, the kitchen was short staffed and the refrigerators were not cleaned out to ensure food was discarded if it was over three days from the date indicated on the package. He said the leftover food policy was three days. VIII. Can opener was dirty A. Professional reference The Food and Drug Administration (FDA) Food Code (2019) pp. ,[DATE], in regards to kitchen equipment, read in pertinent part . Except when dry cleaning methods are used, surfaces of utensils and equipment contacting food that is not time/temperature control for safety shall be cleaned at any time when contamination may have occurred .Non food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues . B. Observations On [DATE] at 11:15 a.m., visible food debris was observed on the can opener that was attached to the countertop. There was a dark substance all around the base of the can opener and can shavings were on the blade. C. Staff interviews The DM was interviewed on [DATE] at 11:00 a.m. He said he expected the can opener to be cleaned at least once a day. He said he saw that the can opener was sticky and had a brown crust around the base, but had not taken the can opener off the base to clean around it. VIIII. Wiping cloth bucket Observations and interviews On [DATE] at 12:05 p.m., the DM was observed walking to the dish room with a green cloth wiping bucket. He proceeded to pour ammonia into the wiping bucket and fill the bucket with water. When asked how he knew what the parts per million (ppm) was, he said he did not know, as he did not have any test strips. The DM was observed to clean the preparation table. On [DATE] at approximately 12:00 p.m., the DM was observed wiping the preparation table with a cloth from the wiping bucket. He said he still did not have the ammonia test strips, so he continued to not know what the ppm was for the ammonia in his wiping bucket. X. Overall cleanliness, function, and repair Observations On [DATE] The fan was dirty and was blowing toward the tray line. There was a hole in the wall above the steam table, and two quarter sizes and a screw that is combining out of the wall, above the steam table. The dirty mop head was still in the dish room on the floor, along with the dirty rag that was still there. The pipe had a dirty rag on the drain from the dishmachine. The mixer and the slicer continue to be uncovered as was on the first entry into the kitchen. Interview The regional environmental director (RED) was interviewed on [DATE] at approximately 11:00 a.m. The RED said he had walked through the kitchen yesterday and had identified the above and said he was getting a plan together to gets all the items clean and fixed.
F 0835 **Level of harm -** Actual harm **Residents Affected -** Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically: Record review and interviews with staff involved in nutrition and hydration management revealed an ineffective system in implementing facility policy on and surrounding nutrition and in maintaining acceptable nutritional parameters These failures contributed to a pattern of residents experiencing severe weight loss. Cross Reference F 692 H; F 803 F 806 F 809 Findings include: A. Current findings in area of quality of care - Failure to ensure facility policy was implemented to identify, prevent, asses and treat weight loss for Residents #1, #2, #3, #4, #5 and #6. 1. Facility Policy A. The Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol revised September 2012, was provided by the nursing home administrator (NHA) on 6/4/2020 at 9:35 a.m. It revealed in pertinent part: The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time. The staff and physician will define the individual ' s current nutritional status and identify individuals with anorexia, recent weight loss, and significant risk for impaired nutrition. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a) 1 month - 5% weight loss is significant; greater than 5% is severe, b) 3 months - 7.5% weight loss is significant; greater than 7.5% is severe, c) 6 month - 10% weight loss is significant; greater than 10% is severe. The physician, with the help of the multidisciplinary team (IDT), will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequences of weight loss and/or impaired nutrition. The physician will review possible causes of weight loss with the nursing staff and/or dietician before ordering interventions. The physician (or staff, based on a discussion with the physician) will document relevant medical observations and, regarding the nature, severity, causes, and consequences of impaired nutritional status, especially in complex situations or where multiple, active causes may co-exist. The staff and physician will identify any pertinent interventions based on identified causes and overall

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F 0835 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 8) resident condition, prognosis, and treatment wishes. Treatment decisions should consider all pertinent confirmation or evidence, such as food intake and overall condition. Nutritional needs: The dietician will help the physician determine the appropriate diet for the resident based on the resident ' s degree of nutritional impairment. Environmental factors: Staff will ensure that the food served to the resident has an appealing aroma, flavor, form, temperature, and appearance. Supplementation: Strategies to increase a resident ' s intake of nutrients and calories may include fortification of food, providing between-meal snacks and/or nutritional supplementation. The physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include: Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals; Evaluating the resident ' s response should be based on defined criteria for improvement/worsening of nutritional status; Observing for and documenting any sustained decline in appetite and/or food intake; and Observing for and reporting significant weight gain and/or loss. B. The Weight Pathway Policy was provided by the NHA on 6/4/2020 at 9:35 a.m. It read, in pertinent part: In the event the weight of the resident varies +/- three lbs from the prior weight, the restorative aide must solicit the treatment and lead to witness a reweight. In the event the weight remains the same it will be documented, with two separate entries, and reweighed the following day. In the event the weight still varies the following day, a progress note will be made, the doctor and registered dietitian (RD) made aware of change, and change of condition process started for nurses where they document every shift on the encouragement of fluids if applicable, intake of residents, or any change in eating patterns. The interdisciplinary team (IDT) will meet to review weights. The weight summary report should be pulled with a six month lookback for review. These will be the weights to review, no other report to be utilized. It is the expectation that the director of nursing (DON) would attend the monthly weight meeting. Weekly weights determined in the meeting were based on criteria of residents with greater than 3 lbs from the last weight, 5% in 30 days, 7% in 90 days or 10 % in 180 days. All interventions are to be care planned in the moment at IDT for any resident that is added for review every week. Nutrition at Risk (NAR) meetings should include minimally the Director of Nursing, and the dietary manager, weekly. The Dietician, Social Services, activities and administrator should be included monthly in the initial meeting for the month. Ensure actual intakes are reviewed prior to the NAR meeting and every day. Use the alert on your dashboard as a way to guide the staff to be proactive. That information is something the dietary manager should assess. Minimum intake for fluids, food, and protein will be based on your Dietician ' s assessment so please ensure documentation is occurring. When performing a NAR review and determining interventions ensure you recap what was previously tried, review the care plan and ensure implementation is plausible. 2. Cross reference F692H. Facility administration failed to timely and comprehensively identify, assess, prevent severe weight loss. These failures created situations that resulted in a pattern of harm. -Observation, record review, and interviews with staff, health professionals, and residents demonstrated the facility did not have an effective system in place to implement preventive measures for residents who had been assessed to be at risk for weight loss. Nursing staff did not consistently provide meal assistance, ensure weights were accurate, notify the responsible party of severe weight loss, involve the registered dietitian timely, and did not offer alternatives when the meal was not consumed. -Severe weight loss was not monitored or interventions were not implemented timely. The facility did not have formal weekly nutrition at risk (NAR) meetings, and assessments completed. -Record review and interviews with staff involved in nutrition management revealed an ineffective system in implementing facility policy (above) and in how to identify, implement, monitor, and modify interventions (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards of practice, to maintain acceptable parameters of nutritional status. Resident #1 experiencinced an 18 percent (%) (severe) weight loss Resident #5 experiencing a 21% (severe) weight loss Resident #2 experiencing a 9.71% (severe) in three months Resident #3 experiencing an 11.85% (severe) weight loss in three months Resident #4 experiencing a 9.57% weight loss in three months Resident #6 experiencing a 6.82% (severe) weight loss in one month. The facility's failure to identify its systemic issues in its management of residents at risk , including the lack of preventative measures for at risk residents, the lack of formalized weekly NAR meetings, provide meal assistance, identify, implement, monitor, and modify interventions (as appropriate), consistent with the resident ' s assessed needs, choices, preferences, goals, and current professional standards of practice, to maintain acceptable parameters of nutritional status, contributed to a pattern of residents having severe weight loss. Interviews The director of nurses (DON) was interviewed on 6/1/2020 at 3:05 p.m. The DON said she had worked at the facility since January 2020. She said that she was aware there were residents who had severe weight loss. She said prior to the 5/21/2020 NAR meeting with the RD, the NAR meetings were informal and she said that was her error. She said they did not have an RD to bounce things off of. She said the previous RD was asked to review, however she did not ask again, when they were not completed and did not follow up. The nursing home administrator (NHA) was interviewed on 6/1/2020 at approximately 4:00 p.m. the NHA said he was aware there were residents who had weight loss. The NHA said the facility had a RD who did not respond to requests, and ended his contract abruptly on 4/17/2020. He said the corporation did not have any other RD ' s which he could utilize to assess residents. The registered nurse consultant was interviewed on 6/1/2020 at 5:26 p.m. The RNC said he had been working for the facility only a few months. He said 5/16/ 2020 he had identified there were a lot of weight discrepancies. He said he had been working on the weights since. He said the residents were to be re-weighed if there was a plus or minus of three pounds. However, regardless, of the weight when a weight loss was suspected, the physician and the RD needed to be contacted. The director of operations was interviewed a second time on 6/3/2020 at 11:00 a.m. She said the facility did have access to an RD who worked for one of the related facilities, and that the RD was always available to assist. She said she would arrange for a dietary manager from another building to provide training to the dietary staff. The NHA and the director of operations were interviewed on 6/3/2020 at 11:45 a.m. The NHA said he was aware there were residents who had weight loss. He said the residents were reviewed in the weekly NAR meetings, and that timely interventions were put into place. He said he was not aware snacks were not always available for residents. The DON was interviewed on 6/5/2020 at approximately 11:00 a.m. The DON said she was unable to provide copies of the meal intakes for Resident #1,#2, #3, #4, #5, #6 for the months of February 2020 though June 2020, as they were not completed. She said she had now provided training to the staff to record food intake. The MD was interviewed on 6/5/2020 at 11:45 a.m. The MD said he had been the MD for the facility for the past two years. He said he attended QAPI on a monthly basis. He said prior to COVID 19 he would come into the building at least five or six times a month. He said that he followed the corporation policies. He said every month in the QAPI meetings, he reviewed different reports, such as the safety fall reports, skin reports, resident council and the nutrition at risk. The MD said at the last QAPI meeting weight loss was discussed. He said that the team discussed the current challenges of staffing, and the COVID 19 restrictions. He said that some [DIAGNOSES REDACTED]. He said he did not direct the care, but that it was a group discussion. The new team had challenges and together they worked collaboratively. He said from the team discussion, he did not follow up on any suggestions. He said he had good faith and the team had best intentions, and he did not think he needed to follow up. He said at the next QAPI meeting he will get a recap of what the facility did as follow up.
F 0841 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff, medical director interviews and record review, the facility failed to ensure all responsibilities of the medical director were effectively performed, which had the potential to affect all residents of the facility. Specifically the facility failed to ensure: -The medical director fulfilled his responsibility for the implementation of resident care policies or the coordination of medical care in the facility Cross reference F 692 nutrition and hydration and F 809 Frequency of meals and snacks Findings include: I. Medical director agreement The medical director (MD) independent contract agreement was signed 6/1/18. The agreement documented:, Physician shall: oversee coordination of medical care in the facility, help the Facility obtain and maintain timely and appropriate medical care that supports the healthcare needs of the residents, is consistent with current standards of practice, and helps the Facility meet its regulatory requirements, address issues related to the coordination of medical care identified through the Facility ' s performance improvement committee. And oversee other activities related to the coordination of care, which may include: but is not limited to helping the facility. II. Record review The quality assurance performance improvement (QAPI) committee sign in sheets showed the MD participated in the QAPI meetings on 3/5/2020, 4/2/2020, and 5/7/2020. III. Interview The MD was

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	**4001 HOME ST CASTLE ROCK, CO 80108**

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 0841 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 9) interviewed on 6/5/2020 at 11:45 a.m. The MD said he had been the MD for the facility for the past two years. He said he attended QAPI on a monthly basis. He said prior to COVID 19 he would come into the building at least five or six times a month. He said that he followed the corporation policies. He said every month in the QAPI meetings, he reviews different reports, such as the safety fall reports, skin reports, resident council and the nutrition at risk. The MD said at the last QAPI meeting weight loss was discussed. He said that the team discussed the current challenges of staffing, and the COVID 19 restrictions. He said that some [DIAGNOSES REDACTED]. He said he did not direct the care, but that it was a group discussion. The new team had challenges and together they worked collaboratively. He said from the team discussion, he did not follow up on any suggestions. He said he had good faith and the team had best intentions, and he did not think he needed to follow up. He said at the next QAPI meeting he will get a recap of what the facility did as follow up. The MD said in a lot of other buildings the nursing homes were not doing weights, however, universally, the plan the facility was doing was hiring a registered dietitian, making supplements available and the third layer if someone was losing weight, then a hospice referral could be obtained. He said he thought snacks were available and about a month ago it was discussed that residents were requesting peanut butter and jelly sandwiches. However, no follow up was conducted to ensure enough sandwiches were available.