STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43525 Based on observations, record review, and interviews, the facility failed to ensure reasonable accommodations of needs for one (#6) of three residents reviewed out of 24 sample residents. Specifically, the facility failed to provide an appropriate size shower chair to accommodate Resident #6's needs and shower preference. Findings include: I. Resident #6 A. Resident status Resident #6, age 58, admitted [DATE] and readmitted on [DATE]. According to the January 2022 computerized physician orders (CPO), the diagnoses included multiple sclerosis (disease with nerve damage to the brain and spinal cord), flaccid hemiplegia (paralysis of one side of the body), contracture, dysphagia (difficulty swallowing), functional quadriplegia (paralysis of all four limbs), and chronic pain syndrome. The 1/4/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status score of 15 out of 15. He required extensive assistance of two people for transfer, bed mobility, dressing, personal hygiene and toileting, and extensive assistance of one person with eating. B. Resident interview Resident #6 was interviewed on 2/7/22 at 1:00 p.m. He said he had to have bed baths because the shower chair was not long enough. He said he was six feet three inches tall, so his feet would drag and his buttock did not fit right in the facility shower chair. He said he wanted to have a shower. He said he used to get showers, but because of the discomfort with the shower chair, he needed to have bed baths now. He said he told his nurse a while ago, but nothing had changed. C. Record review (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activities of daily living care plan, initiated on 3/28/18 and revised 5/5/21, revealed the resident required assistance and was dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. The interventions included the resident preferred a bed bath in the morning every day. It indicated the resident also wanted two showers per week and as needed. -However, according to the resident's interview above, he prefered to have showers but the facility did not have a shower chair to accommodate him. The 6/19/19 bathing preferences documented that the resident wanted a shower the morning, three times per week with no caregiver preference. D. Staff interview Certified nurse aide (CNA) #6 was interviewed on 2/8/22 at 9:10 a.m. She said Resident #6 used to get up in the shower chair to get to showers, but he preferred to have bed baths now. She said he was very tall and very stiff with his medical condition, so it was hard for him to fit in the shower chair. CNA #6 said the facility had two types of shower chairs in the shower room; one was a sitting shower chair, and another one had an adjustable head and leg support for residents to lay down. She said Resident #6 could not fit in the sitting shower chair and in the reclining shower chair either because he was too tall and his legs could not be bent. She said she had told the licensed nurse, but she did not know if anyone had told the managers about ordering a different type of shower chair for Resident #6. The director of nursing (DON) was interviewed on 2/9/22 at 12:30 p.m. She said the facility should provide all types of assistive equipment to meet each resident's needs. She said if a resident preferred to shower but the shower chair did not fit well, the therapy department should assess the resident and order a customized shower chair to fit the resident's need. She said no staff had brought Resident #6's concern to her attention. She said she would have the therapy department assess Resident #6 to determine the appropriate shower chair to meet the resident's needs. -The facility did not provide the therapy assessment before survey exit on 2/9/22.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and interviews the facility failed to ensure residents had the right to formulate advance directives by not keeping advance directives updated and current for two (#5 and #3) of two residents reviewed for advance directives out of a 24 total sample residents. Specifically, the facility failed to ensure the medical orders for scope and treatment (MOST) forms matched the resident's electronic medical record (EMR) physician orders. Findings include: I. Policy and procedure The Code Status Orders policy and procedure, created on [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 9:00 a.m. It revealed, in pertinent part, Code status communicates to the clinical staff whether the patient desires cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest. Patient identification mechanisms and information about each patient's code status (Full code versus Do Not Resuscitate (DNR)) will be easily accessible to the clinical staff for all patients. All patients require a code status order as soon as possible upon admission/readmission, a change in patient preference, or a significant change in patient condition. Staff should verify the patient's wishes with regard to code status (Full Code versus DNR) upon admission If the patient wishes are different than the admission orders, immediately document the patient's wishes in the medical record, notify the physician, and obtain the correct order. II. Professional reference (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Colorado Advance Directives Consortium, Guidance for Health Care Professionals website, dated [DATE], retrieved on [DATE] from http://www.coloradoadvancedirectives.com/wp-content/uploads/[DATE]-MOST-Booklet-REV-2015.pdf read in pertinent part, If the individual resides in a nursing facility, the facility staff are responsible for keeping the MOST form updated. Staff should complete MOST forms for all current residents before the next scheduled quarterly care plan meeting and review the form automatically before each resident's quarterly assessment. For current residents, complete or review at quarterly conference(s). For section A of the form, cardiopulmonary resuscitation (CPR), selecting ' Yes CPR' requires choosing Full Treatment in section B. The form must be dated. A revised MOST form automatically supersedes all previously completed MOST forms. The MOST form must be completed by a healthcare professional with sufficient expertise to discuss medical conditions, treatments, risks and benefits with the individual. This professional should be competent and comfortable with conducting this kind of conversation. The form must be signed by a physician (MD or DO), advanced practice nurse, or physician's assistant and the individual, assuming the individual has decisional capacity. III. Resident #5 A. Resident status Resident #5, age 62, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnosis included: cerebral infarction (CVA), type 2 diabetes mellitus (DM2), heart failure, chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD), morbid obesity, and chronic respiratory failure. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. He required limited assistance of one person for bed mobility, transfers, dressing, toileting, and personal hygiene. B. Record review The [DATE] MOST form documented Resident #5 wished to be a full code and receive CPR if his heart was to stop beating. The resident signed the MOST form. The [DATE] CPOs documented the following physician order: -Code status: do not resuscitate - ordered [DATE]. C. Resident interview Resident #5 was interviewed on [DATE] at 2:30 p.m. He said he reviewed his MOST form with the doctor a couple months prior. He said he wished to be a full code and receive CPR if necessary. IV. Resident #3 A. Resident #3 status (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3, age 77, was admitted on [DATE] and discharged on [DATE]. According to the February 2022 CPO's, the diagnosis included: depression, hypertension, gastroesophageal reflux disease (GERD), and hyperlipidemia. The [DATE] MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. He required extensive assistance with two or more persons for dressing and personal hygiene. B. Record review The [DATE] MOST form documented that the resident wished to be a DNR (do not resuscitate). Resident #3 signed the MOST form. The [DATE] CPOs documented the following physician order: -Code status: full code - ordered [DATE]. The discharge summary form completed by RN #1 on [DATE] at 10:00 a.m. indicated Resident #3 was full code III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 9:54 a.m. She said the MOST form was reviewed with each resident upon their admission to the facility. She said if the resident was not able to complete the MOST form due to cognitive impairment, she reached out to the power of attorney (POA) to get verbal consent. LPN #1 said if she found a resident unresponsive she would check the physician orders for the resident's code status. She said there was a binder at the nurses station that also had paper copies of each resident's MOST form. She said the MOST form and the physician orders should match. LPN #1 confirmed Resident #5 signed a MOST form on [DATE] indicating he wished to be full code and the physician orders documented the resident was DNR. The NHA and director of nursing (DON) were interviewed on [DATE] at 12:30 p.m. The DON said the MOST form was completed with the resident upon admission to the facility. She said if the resident had cognitive impairment the nurses were responsible for contacting the POA to fill out the MOST form. The DON said most residents came to the facility from the hospital with a MOST form in place. She said in that situation the nurses should have reviewed the MOST form with the resident. If the MOST form was different from the residents' wishes, the nurse should contact the doctor and receive new orders. The DON said the physician reviewed the MOST form with the resident on a quarterly basis. The DON said if a nurse found a resident unresponsive they should check the physician orders or the MOST form to find the resident's code status. She said the MOST form and the physician orders should have the same code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She acknowledged Resident #5 and Resident #3's MOST form did not match the physician orders.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on observations and interviews, the facility failed to provide a comfortable and homelike environment for the residents on four out of six hallways. Specifically, the facility failed to ensure resident rooms were cleaned regularly, providing a clean and sanitary environment. Cross-reference F880: the facility failed to ensure resident rooms were cleaned and sanitized within accepted infection control standards of practice. Findings include: I. Facility observations A. 300 hallway On 2/1/22, at 9:04 a.m. in room [ROOM NUMBER], food (chips) debris was observed under and in front of the resident's bed. On 2/3/22, beginning at 10:12 a.m., the following was observed: -In room [ROOM NUMBER], a banana, which was dark black in color, was observed on the ground near the head of the resident's bed. A red and orange powdery substance was observed all over the floor with unrecognizable food debris in front of and underneath the resident's bed; and, -In room [ROOM NUMBER], used tissues were observed on the floor by the door, the resident's bed and the closet. Used paper towels were observed near the sink and by the doorway in the bathroom. B. 400 hallway On 2/1/22, beginning at 9:04 a.m., the following was observed: -In the hallway, trash was observed on the floor with multiple coffee and juice spill stains. The floor was sticky; -In room [ROOM NUMBER], trash was observed on the floor, with food debris scattered in the middle of the room and underneath the resident's bed; -In room [ROOM NUMBER], trash was observed on the floor throughout the room. The trash can was overfilled; and, -In room [ROOM NUMBER], used tissues were observed on the floor, not near the trash can. On 2/1/22, beginning at 2:23 p.m., the following was observed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the hallway, the floor was still observed to be dirty with coffee and juice spill stains and sticky. Trash was observed on the floor; -In the hallway, outside room [ROOM NUMBER], a brownish colored stain was observed with an unidentifiable piece of trash; -In room [ROOM NUMBER], the floor was visibly dirty with a straw wrapper and a white colored piece of trash on the floor; and -In the hallway by room [ROOM NUMBER], a brown coffee stain was observed on the floor and an orange colored stain was observed outside room [ROOM NUMBER]. On 2/2/22, beginning at 9:18 a.m., the following was observed: -In room [ROOM NUMBER], the floor was visibly dirty with brown and orange stains and grimy wheel marks across the room from the A side to the B side with large grey/brown stains on the A side of the room; -In room [ROOM NUMBER], a resident's dirty garment was observed on the floor. The floor had trash and other debris, dirty build up and grime found around the closet and floor boards, and food on the ground at the foot of the bed on the B side of the room. The bathroom floor was dirty with pieces of tissue and toilet paper on the ground, and yellowish stains on the commode; -In room [ROOM NUMBER], the B side of the room had a lot of food debris throughout the room and unknown pieces of trash underneath the bed; and -In room [ROOM NUMBER], a visibly stained pile of clothing was observed on the floor by the closet. On 2/3/22 at 10:12 a.m., food debris was observed on the floor in the resident's room. It was observed near the entrance to the room and underneath the resident's bed. C. 500 hallway On 2/1/22, at 9:08 a.m. in the hallway outside room [ROOM NUMBER], the floor was visibly dirty with debris and dust [NAME] build up, spots of dirt by the nursing station. On 3/3/22, beginning at 10:12 a.m., the following was observed: -In room [ROOM NUMBER], food debris was observed on the ground and underneath the bed. Cheese puffs were observed on the ground, near the resident's bed; and, -In room [ROOM NUMBER], a pile of visibly dirty clothing was observed in a pile on the ground, next to the closet. D. 600 hallway On 2/1/22, beginning at 9:08 a.m., the following was observed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the hallway on the 600 unit, coffee and juice spills were observed on the floor. The floor was sticky. Used tissues, paper towels and used gloves were observed on the floor throughout the hallway. II. Staff interviews The housekeeping account manager (HAM) and the housekeeping district manager (HDM) were interviewed on 2/9/22 at 1:42 p.m. The HAM said each resident room was scheduled to be cleaned every day and deep cleaned once per month. He said the daily cleaning of resident rooms included the bedroom and the bathroom. He said each room should be swept and mopped every day. He said the hallways throughout the facility were cleaned every day. He said they had a machine that cleaned and polished the hallways, weekly. He said he felt like the facility had enough housekeeping staff to keep the facility clean. He acknowledged, during the survey process, the resident rooms and hallways were not as clean as he would expect. He said, over the weekend during the survey process, the facility had deep cleaned the majority of resident rooms and the hallways. He said he did not know why the resident rooms and hallways had beverage stains, food debris, and trash consistently on the floor, throughout the facility, during the survey process. The HDM said she would provide the housekeeping staff education on the cleaning process for resident rooms and hallways throughout the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45889 Based on interviews and record review, the facility failed to ensure two (#10 and #21) out of four of 24 sample residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to: -Ensure Resident #10's request for a prosthesis for a bilateral above the knee amputation was addressed timely and communicated with the resident; and, -Ensure the facility responded to Resident #21's missing eye glasses in a timely manner. Findings include: I. Facility policy and procedure The Grievance/Concern policy and procedure, revised November 2021, was provided by the nursing home administrator (NHA) on 2/10/22 at 10:38 a.m. It revealed, in pertinent part, The resident has the right to voice grievances to the Center or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their Center stay. All residents and/or their representatives may voice grievances/concerns and recommendations for changes. Center leadership will investigate, document, and follow up on all concerns and grievances registered by any resident or resident representative. Social Services personnel will serve as patient advocates in the grievance/concern process. II. Resident #10 A. Resident status Resident #10, age 65, was admitted on [DATE]. According to the January 2022 clinical physician orders (CPO) diagnoses included type 2 diabetes mellitus, peripheral vascular disease, reduced mobility, acquired absence of right leg (above the knee amputation) and acquired absence of left leg (above the knee amputation). The 10/31/21 minimum data set (MDS) documented the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. The resident required supervision with set up assistance for bed mobility, transfers, dressing, eating, toileting and personal hygiene. B. Record review (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activity of daily living (ADLs) care plan, revised 5/11/21, revealed the resident was at risk for alterations in functional mobility related to bilateral above the knee amputations. The interventions included to provide adaptive equipment for activities of daily living as indicated. The discharge care plan, revised on 11/4/21, documented the resident's long-term goal was to return to the community. The interventions included evaluating the resident's discharge potential as needed and consider care plans, resident goals, cognitive skills, functional mobility and the need for assistive devices throughout discharge planning. The January CPOs documented the following physician order: -Referral to a prosthetic and orthopedic clinic for evaluation to obtain prostheses for the diagnosis of bilateral leg above the knee amputations-ordered on 9/8/2021. -Discontinuation of skilled occupational therapy (OT) services on 11/12/21 and again on 1/20/22 due to meeting all of the resident's highest therapeutic potential. C. Resident #10 interview Resident #10 was interviewed on 2/7/22 at 9:43 a.m. He said he had been asking about getting prosthetics since he was admitted in May 2021. He said that the prosthetics were ordered in September 2021 by his physician. He said the physician told him that he was strong enough to start using prosthetic legs. Resident #10 said the physical and occupational therapists at the facility limited his therapy to stretching exercises but that he would come back to his room and work out his arms with exercise bands. He said he did not want to lose his independence or lay in bed all day and get depressed. Resident #10 said he asked the staff numerous times about the prosthetics and was told by the staff to ask the director of rehabilitation (DOR). The resident said he was told by therapy that his physician had approved his prosthetic legs but was given excuses from the therapy department as to why he could not get them. He said he was told the facility did not have the money to pay for two prosthetics. He said he was told that the technician that made the prosthetics went on vacation for the entire month of December every year. The resident said that he wanted to get better and go home. D. Staff interviews The DOR was interviewed on 2/9/22 at 9:46 a.m. The DOR said that she recalled that Resident #10's previous physician refused to order prosthetics due to the resident having a sacral wound, which had since been healed. The DOR said the physician did not feel Resident #10 would benefit from prosthesis because of his skin issue and did not feel the resident was strong enough. The DOR said the resident's new physician had ordered a prosthetics referral for the resident in September 2021. She said then the referral was sent to a local prosthetic and orthotic company. The prosthetic and orthotic company required measurements from an orthopedic physician. The DOR said she was unable to get Resident #10 an appointment with a local orthopedic surgeon. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It indicated the resident had impaired vision. B. Observations On 2/8/22 at 10:30 a.m. Resident #21 was observed in his room. He asked housekeeper (HSKP) #1 to help him find his glasses. HSKP #1 was unable to locate Resident #21 ' s glasses. At 10:35 a.m. licensed practical nurse (LPN) #2 entered the residents room and attempted to locate the residents' glasses. She told the resident she was unable to find them and would call his sister to see if she took his glasses home with her. She said he had been missing his glasses for a while. B. Resident interview Resident #21 and his representative were interviewed on 2/8/22 at 12:00 p.m. The resident's representative said she filed a grievance approximately two months prior with the facility reporting the missing glasses. She said she had not heard back from the facility staff since she filled the grievance. She said the facility had not done anything to find or replace the missing glasses. C. Record review The facility was unable to provide documentation of a grievance filled by Resident #21 ' s representative regarding the missing glasses during the survey process. D. Staff interviews The social services director (SSD) was interviewed on 2/9/22 at 11:52 a.m. She said the social services department was responsible for handling any grievances filed by resident ' s and/or resident representatives. She said the grievance form was then given to the appropriate department for the investigation and follow-up. She said grievances should be resolved within 72 hours. She said she was responsible to follow up with the resident and/or family to ensure the grievance was resolved by the department it concerned. The grievance was then filed and put on the grievance log. The SSD was interviewed on 2/9/22 at 12:13 p.m. She said she was unable to find documentation of a grievance filed regarding Resident #21 ' s missing glasses. She said she called the resident's representative and located the glasses in the nurses cart. She said she returned the glasses to the resident. The nursing home administrator (NHA) and director of nursing (DON) were interviewed on 2/9/22 at 12:30 p. m. The DON said the SSD received grievance forms from the residents and/or family members. She said the SSD provided the grievance to the correct department to conduct the investigation and follow-up. She said grivacances were reviewed in the interdisciplinary team (IDT) meeting every morning. She said the SSD was responsible for following up with the resident and/or family and entering the grievance on the grievance log for tracking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she was not notified of Resident #21 ' s missing glasses. She said a grievance should have been filled out and followed up on when the glasses were initially reported as missing.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on record review and interviews, the facility failed to ensure one (#2) out of 24 sample residents were kept free from neglect. The facility failed to ensure Resident #2 was not neglected by staff by providing the care and services the resident required to maintain the highest practicable well-being. This is evidenced by the following statements. Specifically, the facility failed to ensure Resident #2 received the care and services required to prevent an avoidable pressure injury from developing and worsening. On 8/6/21, the resident's representative reported she had informed a male nurse that Resident #2's right ear had been bleeding six weeks prior. The resident's medical record did not reveal documentation that the resident had been assessed when the injury was reported to the nurse and all prior skin checks documented no skin injury. According to the hospital documentation on 8/3/21, Resident #2's right ear wound was classified as a deep wound that had continuous pressure causing a pressure injury which led to a defect in his right ear with signs and symptoms of an infection. After the resident returned from the hospital on 8/3/21, the facility failed to provide the treatment and services consistent with accepted standards of practice by failing to provide the physician ordered treatment on seven occasions. Findings include: I. Facility policy and procedure The Abuse policy and procedure, revised April 2021, was provided by the nursing home administrator (NHA) on 2/10/22 at 10:30 a.m. It revealed, in pertinent part, (The facility) prohibits abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all patients. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restrain not required to treat the patient's medical symptoms. Neglect is defined as the failure of the (facility), its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. II. Resident #2 A. Resident status (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #2, age 78, was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the November 2021 computerized physician orders (CPO), the diagnoses included schizoaffective disorder bipolar type and dermatitis. The 10/22/21 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status score of 12 out of 15. He required supervision with set up assistance with bed mobility, transfers, dressing, eating, toileting and personal hygiene. It indicated the resident did not reject care during the assessment period. It indicated the resident was at risk for pressure injuries. B. Record review The skin integrity care plan, initiated on 6/25/19, documented the resident had a risk for skin breakdown related to dry skin, dermatitis, discolored fingers and hands from smoking, weakness, impaired cognition and incontinence. The interventions included: observe skin for signs and symptoms of skin breakdown, evidenced by: redness, cracking, blistering, decreased sensation and skin that does not blanch easily; observe the resident's skin condition daily with activities of daily living (ADL) care and report abnormalities; and conduct a weekly skin assessment by the licensed nurse. The ADL care plan, initiated on 6/26/19, documented the resident was at risk for decreased ability to perform ADLs related to impaired cognition, behaviors and weakness. The resident required supervision and set up assistance for most ADLs. The resident required limited assistance from one staff member with personal hygiene, grooming and bathing. The risk for contracting and spreading COVID-19 care plan, initiated on 10/19/2020, documented that the resident refused to wear his mask at times in the common areas and did not practice social distancing. The resident would become verbally angry and not follow re-direction given by staff members. It indicated the resident frequently refused to change the face mask when it was soiled. The interventions included to provide the resident with education related to COVID-19, state and federal recommendations for long-term care facilities; social services to work one on one with the resident and his family to encourage mask wearing, social distancing and frequent hand hygiene when in common areas; staff to remind the resident of COVID-19 precautions, mask wearing, social distancing, isolation precautions and hand washing every shift when in common areas; and staff to report when the resident did not adhere to social distancing and handwashing to the social services department and the unit manager. C. Failure to prevent an avoidable pressure injury from developing and worsening The 6/17/21, 6/24/21, 7/1/21, 7/8/21, 7/22/21 and 7/29/21 skin check assessments documented a skin check was performed with no skin injury or wounds. The 8/3/21 nursing progress note documented the resident had sustained a wound on his right ear. The strap of the facial mask was cutting into the cartilage of the resident's right ear. The physician was notified and indicated he would be at the facility the following day to assess the wound. He ordered that a wound consult be completed for the resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 8/3/21 change of condition assessment revealed the resident had a deep wound into the cartilage of the resident's right ear. It had a three plus cap refill (a measure of the time it takes for a distal capillary bed to regain color after pressure has been applied to cause blanching), was not bleeding, but was oozing scant serous fluid (signs of infection). The recommendation included for the resident to be evaluated at the hospital. The unit manager assessed the wound and determined the wound needed to be stitched and the resident should be sent to the hospital. The physician and power of attorney (POA) were notified and the resident was transported to the hospital. The 8/5/21 nursing progress note documented that the resident's representative had come to the facility that morning. She had several concerns regarding the wound to the resident's right ear. She said she was not informed the resident had been sent to the emergency room for the wound to be evaluated. She said a month and a half ago, she had noticed the resident's ear was bleeding and told the male nurse. She entered the resident's room and found multiple facial masks with ear loops. The nurse apologized, removed the facial masks and provided the resident with a face shield. The nurse said she would notify the NHA of the resident's representative concerns. -The facility failed to identify the wound caused by the facial mask and consistently documented no skin concerns on the weekly skin assessments, put a treatment in place prior to the wound worsening from the mask digging into the resident's ear, into the cartilage and resulting in oozing serous fluid. The facility failed to assess and document the wound to the resident's right ear when it was reported by the resident representative six weeks prior to the documentation of 8/3/21. D. Hospital documentation The 8/3/21 emergency room physician notes documented Resident #2 was sent to the emergency department because of a sore to the resident's right ear. The resident said he received one shower per week, and asked staff for assistance in the shower, however staff would tell him, no you can do it by yourself. He said the staff would leave him alone in the shower room. The resident said he wore his mask all of the time. It documented the resident had a deep laceration to the right ear from a facial mask being left on for an unknown amount of time. The laceration was 2 cm (centimeters) in length, completely open and detached approximately 0.5 cm back from his scalp on the helix (outer rim), starting at the top of the helix to the right ear, going down into his antihelix Crura (part of the visible ear; curved prominence of cartilage parallel with and in front of the helix). There was an additional open sore on the bottom with purulent drainage (white, yellow or brown fluid slightly thick in texture made up of white blood cells trying to fight an infection). The detachment was approximately 0.25 cm in width. The wound was cleaned and irrigated with 100 ml (milliliters) of sterile saline. A large amount of dead skin was removed from behind his ears and inside his cymba and scaphoid fossa of the resident's bilateral ears. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The resident was given an initial dose of antibiotics and sent back to the facility with a prescription to continue the antibiotics for seven days. The resident was provided information for an ENT (ear nose and throat physician) for outpatient follow-up. It documented, When looking at the patient's wound and discussing with the patient his care at the facility seems to be a case of neglect. I had asked the paramedic to call the facility inquiring about his ear. She states that she called the facility and spoke with the nurse at the facility who states that he was sent to the emergency department today because the patient's sister was visiting and noticed there was something wrong with his ear. The nurse then informed her that the patient refuses to bathe quite frequently. When discussing this with the patient, he states he asks for assistance with bathing and is refused assistance, and is left alone in the shower to bathe on his own. I do believe this is neglect. The attending physician documented the wound had continuous pressure causing a pressure injury which led to a defect in his right ear with signs and symptoms of an infection. It indicated the nurse practitioner contacted adult protective services for this chronic injury which appeared to be neglect. E. Failure to provide treatments as ordered by the physician The August 2021 CPO revealed the following physician orders: -Clean wound with wound cleaner with a 4x4 gauze. Apply Aquaphor to the area daily and as needed every day. Discontinue when resolved-ordered 8/3/21, discontinued 8/6/21. -Right ear wound: clean with wound cleaner, pat dry, leave open to air. One time a day for right ear wound-ordered 8/6/21 and discontinued 8/8/21. -Right ear wound: clean with wound cleaner, pat dry, leave open to air every day shift-ordered 8/8/21. The August 2021 treatment administration record (TAR) revealed the treatment to the wound to the resident's right ear was not documented as provided (left blank) on five occasions: 8/10/21, 8/18/21, 8/19/21, 8/20/21 and 8/24/21. The September 2021 TAR revealed the treatment of the wound to the resident's right ear was not documented as provided (left blank) on two occasions: 9/2/21 and 9/7/21. F. Facility investigation The 8/6/21 facility investigation revealed the facility reported an allegation of neglect. It indicated the resident's family accused the facility of neglect due to the development of the wound to the resident's right ear. The resident was sent to the hospital for an evaluation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	It documented the resident had skin checks completed with no concerns identified until 8/3/21 and had refused skin checks in the past. -However, the resident's medical record did not reflect documentation that indicated the resident had refused any skin checks prior to the identification of the wound to the resident's right ear. -The investigation did not include interviews with any staff members regarding the statement made by the resident's representative who informed the nurse a month and a half prior that the resident's ear was bleeding or an attempt to identify the staff member. -The investigation did not include a conclusion or summary of the investigation completed by the facility. III. Staff interviews Registered nurse (RN) #1 was interviewed on 2/9/22 at 11:22 a.m. RN #1 said skin assessments were performed when they show up on the user-defined assessment (UDA) list (in the resident's electronic medical record). She said she preferred completing the assessment when the resident was in the shower or personal hygiene was being performed by the certified nurse aide (CNA) so that she would be able to see the resident's entire body and have help to reposition the resident. RN #1 said the resident should be checked from top to bottom including the head, ears, back, chest, arms, bottom and all the folds, legs, ankles, heels, toes and in-between the toes. The NHA and the director of nursing were interviewed on 2/9/22 at 12:27 p.m. The DON said skin assessments should be completed upon admission by the nurse, weekly and as needed. She said the weekly skin assessments were known as skin checks. She said skin checks were scheduled in the resident's electronic medical record and would show up on the nurses to do for that particular day. The DON said the nurse should put actual eyes on the resident and look at the resident's entire body surface. She said the nurse should document the status of any existing and new skin concerns on the skin check. She said all new skin concerns should be reported to the physician, the resident and/or family, treatment orders obtained and put into place with associated monitoring and updates to the resident's care plan. The NHA said she was not working at the facility during the time Resident #2 sustained a wound to his right ear. The DON said she was working at the facility, however she was out of town during that time. The DON said the former NHA was the lead on the investigation. She said she opened up the investigation, during the survey process, and it only included the documentation submitted through the state portal. She said she was unable to find documentation of the rest of the investigation. She said it appeared as though the former NHA did not try and determine who the male staff member was or complete staff interviews. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	She said Resident #2 had frequent behaviors and refusals. She said she found out Resident #2 had been sleeping in his facial mask. She said she saw the nursing progress note which indicated the resident's representative had reported an ear injury six weeks prior. She said that was not included in the facility investigation. She said the facility did not put any interventions into place following this incident. She said she was unable to find a conclusion to the investigation. She said the documentation from the hospital indicated the wound had been present for a while and had sustained constant pressure. She said the wound should have been documented on the skin checks prior to 8/3/21. She said she would be providing the nursing staff education on how to complete a skin check and ensure the nurses were looking at all the skin surfaces of the resident. She said because she was not there at the time, she did not know if the skin checks were completed correctly, but it appeared as though they were not accurate.

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	065232	A. Building B. Wing	02/09/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, interviews, and record review, the facility failed to ensure three (#18, #20 and #19) of eight residents reviewed out of 24 sample residents for assistance with activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to: -Ensure Resident #18 was provided incontinence care timely; -Ensure Resident #18 and #20 received bathing according to their preference and plan of care; and, -Ensure Resident #19 was assisted with personal hygiene including dressing and nail care. I. Facility policy and procedure The Activities of Daily Living (ADL) policy and procedure, revised on 6/1/21, was provided by the nursing home administrator (NHA) on 2/10/22 at 9:00 a.m. It revealed, in pertinent part, Based on the comprehensive assessment of a resident/patient and consistent with the patient's ADLs are maintained. ADLs include: hygiene (bathing, dressing, grooming, and oral care), mobility, elimination (toileting), dining, and communication. ADL assistance that is not documented within 24 hours of occurring is considered late documentation. The care plan will address the patient's ADL needs and goals, including the provision of ADLS if the patient is unable to perform ADLs. A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. ADL care is documented every shift by the nursing assistant. II. Failure to ensure incontinence care was provided timely A. Resident #18 1. Resident status Resident #18, age 87, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included: diabetes mellitus type two (DM2), dementia with behaviors, delusional disorders, cognitive communication deficit, and irritable bowel syndrome (IBS). (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/18/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score of 12 out of 15. She required extensive assistance of one person for bed mobility, transfers, dressing, toileting, and personal hygiene. It documented the resident was always incontinent of bowel and bladder and required physical help when bathing. 2. Observations During a continuous observation on 2/7/22 starting at 1:23 p.m. and ended at 6:14 p.m. the following was observed: -Resident #18 was sitting by the nurses station with unbrushed and greasy hair. Her hair looked wet, as if it had not been washed in several days (see failure to provide bathing according to her preferences below). Her pants had a hole on the left upper thigh. -Resident #18 waited at the nurses station until she could go on the supervised smoking break. When she was finished smoking, she returned to the nurses station at 2:35 pm. Resident #18 had not been offered or provided incontinence care. -At 4:30 p.m., Resident #18 went on another supervised smoke break. She returned to the nurses station at 5:16 p.m. -At 5:21 p.m. the resident's meal tray was delivered to her room. The nursing staff encouraged her to go to her room to eat. -At 6:08 p.m. an unidentified certified nurse aide (CNA) noticed Resident #18 was sliding down in her wheelchair, the CNA repositioned the resident. Resident #18 sat in her doorway for the remainder of the observation period until 6:14 p.m. and was not offered or provided incontinence care. During a continuous observation on 2/8/22 starting at 8:47 a.m. and ended at 12:52 p.m. the following was observed: -Resident #18 was brought to the unit by a facility staff member. She was observed sitting in the television room, waiting for the first supervised smoke break of the day. She began sliding down in her wheelchair. -Resident #13 was taken outside for a supervised smoke break. She was brought back into the facility by a staff member, after smoking and placed her in front of the nursing station. The facility staff did not offer or provide the resident with incontinence care. -Resident #18 remained in front of the nurses station and in her doorway for the remainder of the observation, she was not encouraged, offered to use the restroom or checked for incontinence. 3. Record Review (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADL care plan, initiated on 7/31/19 and revised on 7/28/21, revealed the resident was at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion, and toileting related to weakness, behaviors, decreased mobility, and dementia. The interventions included to provide the resident assistance with ADLs as indicated and she required one to two person assistance with bathing. The incontinence care plan, initiated on 8/9/19 and revised on 3/17/21, revealed the resident was incontinent of bowel and bladder due to cognitive loss, limited mobility, weakness, and a history of UTIs. The interventions included to assist with perineal care as needed, encourage the resident to ask for staff with perineal care as she was not able to remember and to offer the resident to use the commode as needed. A review of Resident #18's toileting log in her medical record on 2/9/22 at 12:19 p.m. revealed the resident was toileted once on 2/1/22 at 6:59 a.m., toileted three times on 2/7/22 at 4:55 a.m. 4:57 a.m. and at 10:59 p. m, and toileted twice on 2/8/22 at 5:37 p.m. and 10:59 p.m. -It indicated the resident was not toileted for 18 hours on 2/7/22 and 17 hours on 2/8/22, including the continuous observation (see above). B. Staff interviews Licenced practical nurse (LPN) #1 was interviewed on 2/9/22 at 9:54 a.m. LPN #1 said residents should be provided or offered incontinence care at least every two hours or more if needed. She said Resident #18 was incontinent and required assistance using the bathroom. The NHA and director of nursing (DON) were interviewed on 2/9/22 at 12:30 p.m. The DON said incontinence care should be provided every two hours or as needed. She said nursing staff were responsible for documenting incontinence care or toileting assistance in the point of care (POC), which was included in each resident's electronic medical record. III. Failure to ensure bathing was provided in accordance with the resident's plan of care A. Resident #18 1. Observations On 2/1/22 at 9:00 a.m. Resident #18 had visibly greasy hair that looked wet and was unbrushed. She had spilled a brown beverage on her white sweater. The resident remained in the same sweater for the entirety of the observation. On 2/7/22 at 1:23 p.m. Resident #18 was sitting by the nurses station with unbrushed and greasy hair. Her hair looked wet, as if it had not been washed in several days. Her pants had a hole on the left upper thigh. 2. Record review (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The shower care plan, initiated on 6/3/21 and revised on 11/4/21, revealed the resident preferred to have a shower three times a week in the evening, by a female caregiver. The interventions included: to provide opportunities for the resident to choose between a bath, shower, bed bath, or sponge bath. According to the 1/18/22 MDS assessment, she required physical assistance with bathing (see above). The November 2021 shower documentation revealed Resident #18 received bathing on 11/8/21, 11/9/21, 11/10/21, and 11/16/21. She refused a shower on 11/13/21. -It indicated Resident #18 received bathing on four out of 12 opportunities. The December 2021 shower documentation revealed Resident #18 received bathing on 12/3/21, 12/8/21, and 12/20/21. She refused a shower on 12/11/21 and 12/14/21. -It indicated Resident #18 was provided bathing on six out of 13 opportunities. The January 2022 shower documentation revealed Resident #18 received bathing on 1/7/22, 1/22/22, and 1/30/22. She refused showers on 1/3/22, 1/8/22, 1/17/22, and 1/20/22. -It indicated Resident #18 was given bathing on seven out of 13 opportunities. The February 2022 shower documentation revealed Resident #18 received bathing on 2/2/22. -It indicated Resident #18 was provided bathing one out of four opportunities. -Review of the resident's medical record revealed there were no progress notes to indicate why the resident refused showers on multiple dates and the staff had attempted to try at another time to complete the shower when she refused. B. Resident #20 1. Resident status Resident #20, age 61, was admitted on [DATE].According to the February 2022 CPOs, the diagnoses included: chronic obstructive pulmonary disease (COPD), paranoid schizophrenia, diabetes mellitus type two (DM2), chronic kidney disease (CKD), insomnia, tobacco use, bipolar disorder, gastroesophageal reflux disease, and muscle weakness. The 11/23/21 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required supervision assistance with transfers, dressing, toileting, and personal hygiene. It said he had not received a bath during the assessment period. 2. Observations On 2/8/22 at 11:59 a.m. Resident #20 was observed taking his hat off. His hair was matted and was shiny and wet from grease. Resident #20 had several small holes in his pants on the thighs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review The November 2021 shower documentation revealed Resident #20 received a shower on 11/10/21 and 11/11/21. The POC bathing documentation for November 2021 revealed Resident #20 received bathing twice, two out of nine opportunities. The December 2021 shower documentation revealed Resident #20 received a shower on 12/8/21 and 12/27/21. The POC bathing documentation for December 2021 revealed Resident #20 received bathing twice, two out of nine opportunities. The January 2022 shower documentation revealed Resident #20 did not receive a shower the entire month. The POC bathing documentation for January 2022 revealed Resident #20 missed nine opportunities for bathing. The February 2022 shower documentation revealed Resident #20 did not receive a shower. The POC bathing documentation for February 2022 revealed Resident #20 had missed two out of two opportunities for bathing. -A review of Resident #20's medical record on 2/9/22 at 12:00 p.m. revealed the resident's plan of care did not specify shower preferences for the resident. At this time, the resident had not been showered in 44 days according to the shower documentation. C. Staff interviews Licenced practical nurse (LPN) #1 was interviewed on 2/9/22 at 9:54 a.m. She said each resident's shower schedule was determined by their preference upon admission. She said the residents shower preference was documented on the care plan. She said the residents have the right to refuse showers, but staff should attempt to approach residents again to encourage bathing. LPN #1 said Resident #18 could be difficult at times to convince her to take a shower. She said Resident #18 required cueing and set up assistance to brush her hair. CNA #3 was interviewed on 2/9/22 at 10:18 a.m. She said she provided assistance with ADL care. She said she was unsure of how much assistance Resident #20 needed to perform personal hygiene. She said she had never provided assistance to Resident #20. The NHA and director of nursing (DON) were interviewed on 2/9/22 at 12:30 p.m. The DON said each resident's shower schedule was developed based on their preferences obtained at admission. She said the preference sheet was then given to the nurse manager who added the preference to the residents care plan and put it on the CNA's task sheet in the POC. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the residents had the right to receive a shower whenever they desired. She said the standard of practice is two times per week. The DON confirmed Resident #18 should be offered and provided incontinence care every two hours. She said staff needed to ask the resident, as she required cueing. She said Resident #18 could be difficult to convince to take a shower. She said the staff should attempt multiple times to provide a shower before documenting a refusal in the resident's medical record. She said the resident should be provided a shower three times per week. She confirmed Resident #20 should not have gone 44 days without being bathed. -No follow-up documentation regarding Resident #18 or Resident #20's showers were provided before exit on 2/9/22. 45889 IV. Failure to assist with personal hygiene A. Resident status Resident #19, age 89, was admitted on [DATE]. According to the February 2022 CPO, the diagnoses included difficulty walking, muscle weakness, cognitive communication deficit and unspecified dementia. The 1/31/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. He required supervision with setup assistance for bed mobility, transfers, walking, dressing, eating, toileting, personal hygiene and bathing. B. Observation Resident #19 was observed on 2/1/22 at 3:20 p.m. wearing a blue denim button down shirt with multiple spots of dried blood on the left sleeve of the resident's shirt. Resident #19 was observed on 2/3/22 at 10:22 a.m. wearing the same blue denim button down shirt. The spots of dried blood were still present on the left sleeve of the resident's shirt. Resident #19 was observed on 2/7/22 at 12:26 p.m. wearing the same blue denim button down shirt. The spots of dried blood were still present on the left sleeve. Resident #19 was observed on 2/7/22 at 1:57 p.m. wearing the same blue denim button down shirt with spots of dried blood still present on the left sleeve. His fingernails were long and jagged. Resident #19 was observed on 2/8/22 at 8:50 a.m. wearing a different, clean shirt following a shower. His fingernails were still long and jagged. -Resident #19 was able to pick out his own clothes, but the staff were to put them out for him. He was observed above with the same shirt on, on four different days over the course of six days. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review The activity of daily living (ADLs) care plan, revised on 7/25/21, revealed the resident was at risk for decreased ability to perform ADLs related to weakness and debility, and dementia. The interventions included supervision with all ADLs. It indicated the resident required one person assistance at times. The skin integrity care plan, revised on 10/27/21, revealed the resident was at risk for skin breakdown due to weakness and debility, dementia, incontinence, and history of melanoma. The interventions included to provide treatments to skin tears according to physician orders, observe for signs of infection until healed and report changes and the use of arm protectors as ordered by the physician. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 2/8/22 at 9:25 a.m. CNA #1 said the resident dressed himself but the staff set out clothes for him every day. CNA #1 said he was aware Resident #19 had been wearing the same blue denim shirt for a few days in a row. He said he did not assist the resident in changing his shirt. He said he did not notice any blood stains on the left sleeve. CNA #5 was interviewed on 2/8/22 at 2:05 p.m. The CNA said that she assisted Resident #19 with his shower that morning and helped change his clothes. CNA #4 was interviewed on 2/9/22 at 10:04 a.m. The CNA said that residents' fingernails should be trimmed during their shower unless the resident was diabetic. She said if the resident wasdiabetic, the fingernails should be filed by the CNA and the nurse would trim the fingernails. Registered nurse (RN) #1 was interviewed on 2/9/22 at 11:22 a.m. RN #1 said she remembered seeing the blood on the resident's left sleeve on 2/6/22, while she completed the weekly skin check.

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	065232	A. Building B. Wing	02/09/2022

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, interviews and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for two (#3 and #19) out of five reviewed for skin conditions out of 24 sample residents. Specifically, the facility failed to ensure Resident #3 received the care and services to treat existing venous stasis ulcers, prevent the development of additional wounds and the worsening of existing wounds. Resident #3 was admitted to the facility for respite care for seven days. He was admitted to the facility with four venous stasis wounds to his bilateral lower extremities. The 9/8/21 admission nursing assessment completed did not document the resident had any existing wounds. A skin assessment was not completed during his stay at the facility. Resident #3 received home health services on 9/7/21, the day prior to his admission to the facility. The home health wound notes documented four existing wounds, which were evaluated and being actively treated. Resident #3 discharged from the facility on 9/15/21 and received home health services on 9/16/21. According to the home health wound documentation on 9/16/21, three wounds had worsened and Resident #3 had acquired five additional wounds during his respite stay at the facility. The facility failed to evaluate and implement treatments for the wounds, which led to the wounds worsening and the development of five additional wounds (being facility acquired) during his seven day stay. Additionally, the facility failed to document, obtain treatment orders and treat an identified skin tear for Resident #19. Findings include: I. Facility policy and procedure The Skin Integrity Management policy and procedure, last revised on 6/1/21, provided by the nursing home administrator (NHA) on 2/10/22 at 9:00 a.m. revealed, in pertinent part, The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed. To provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. Practice standards include: review pre-admission information to plan for patient's needs prior to admission, complete comprehensive evaluation of the patient upon admission/readmission to the Center, perform daily monitoring of wounds or dressings for presence of complications or declines and document, prior to discharge, provide the patient/family/health care decision maker with instruction regarding specific wound care treatment and document on the 'discharge instructions' section of the discharge transition plan, document daily monitoring of ulcer site, with or without dressing. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0684 Level of Harm - Actual harm Residents Affected - Few	II. Failure to identify Resident #3's wounds and provide the necessary treatment and services A. Resident #3 1. Resident status Resident #3, age 77, was admitted on [DATE] and discharged on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included: depression, hypertension, Gastric reflux disease, and hyperlipidemia. The 9/15/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. He required extensive assistance of two people for bed mobility, transfers, toileting and extensive assistance of one person for dressing and personal hygiene. It indicated the resident did not have any wounds upon admission. 2. Resident representative interview Resident #3's spouse was interviewed on 2/7/22 at 10:48 a.m. She said she was the primary caretaker for Resident #3 and she admitted him to the facility for a seven day respite stay. She said Resident #3 had been receiving home health services for wound management prior to his admission to the facility. She said when the resident discharged from the facility following his respite stay, his wounds had worsened. She said the facility did not provide treatments to his wounds. She said the home health nurse had put on a dressing to his second left toe prior to admission to the facility. She said the dressing had the home health nurse's initials and date. She said the same dressing was on his toe when she brought him home on the day of his discharge from the facility. She said when she had taken the resident home, she noticed he had developed several new wounds. She said she did not receive any information from the facility upon discharge regarding any new wounds. 3. Resident #3's skin condition prior to admission to the facility According to the 9/7/21 home health wound notes, provided to the facility prior to Resident #3's admission by the home health agency, Resident #3 had four venous stasis ulcers. It indicated the resident was being seen on a regular basis for wound care. The notes documented the following: -Wound #1 to the left calf was scabbed over, measured .7 length (L) x .7 width (W) x .1 depth (D) centimeters (cm), dry and intact, with serous drainage; -Wound #2 to the right shin measured 1.1L x 1.1W x <.1D cm, was beefy red in color, intact, and had a small amount of serous drainage; (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Wound #3 to the second left toe measured .7L x 1.0W x .7D cm, intact, with no drainage; and, -Wound #4 to the left third toe was healing, pink, and intact. 4. Resident #3 skin condition, as documented by the facility, upon the resident's admission The 9/8/21 nursing admission assessment did not document any skin concerns for Resident #3, however, according to the home health documentation the resident had a venous stasis ulcer to the left calf, right shin, second left toe, and third left toe. The 9/8/21, 9/9/21, 9/10/21, 9/11/21, 9/12/21, 9/13/21, 9/14/21 and 9/15/21 daily nursing assessments indicated Resident #3 did not have any skin conditions or concerns. The 9/8/21 and 9/9/21 nursing progress notes documented Resident #3's skin was warm and dry. -The facility failed to identify any existing skin concerns from admission, the worsening and the development of new skin concerns. A review of the resident's electronic medical record on 2/8/22 at 9:00 a.m revealed the resident did not have treatment orders or a plan of care implemented that addressed the care for the four venous ulcers while he was admitted to the facility, despite the home health history and physical that documented the four wounds prior to admission. The 9/14/21 discharge plan documentation from the facility documented the resident had weeping areas to his lower extremities and needed to see a wound doctor for treatment. No other assessments or information was documented to indicate the areas were addressed, monitored and treated during the respite stay. 5. Resident #3's skin condition immediately following his discharge from the facility on 9/15/21 The 9/16/21 home health wound notes documented Resident #3 continued with the four venous stasis ulcers he had prior to admission and developed five additional wounds during his stay at the facility. Resident #3 was seen by the home health nurse on 9/16/21 the day after discharging from the facility. The wound notes documented the following: -Wound #1 to the left calf was scabbed over and slightly red. Wound #1 did not worsen during Resident #3's stay at the facility. -Wound #2 to the right shin was not healing, measured 4.7L, 7.3W, and .1D cm, beefy red in color, had large amounts of foul odor serosanguineous drainage, had irregular edges with yellow slough, and was tender to the touch (symptoms of infection). Prior to the resident's admission to the facility, the measurements of the wound were documented as 1.1L x 1.1W x <.1D cm, The wound was beefy red in color, intact, and had a small amount of serous drainage. The wound had worsened during the resident's stay at the facility. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Wound #3 to the second left toe was no longer healing, measured .5L x .9W, x .1D cm, had white slough present, was red and macerated, small amounts of yellow foul smelling drainage, and jagged edges (symptoms of an infection). The home health nurse had treated the wound prior to admission and placed a dressing with her initials and date on the wound. Upon discharge the dressing was still present on the resident's toe, with the home health nurse's initials and date. The wound worsened during the resident's stay at the facility. -Wound #4 to the left third toe was healing and beefy red prior to the resident's admission to the facility. The wound had a blister and was tender to touch following the resident's stay at the facility. The wound notes documented the following wounds were newly developed during Resident #3's respite stay at the facility: -Wound #5 was documented as an unknown wound type to the left fourth toe acquired during the resident's admission at the facility. The wound measured .1L x .1W x.1D cm, dry, red, scabbed, with yellow slough surrounding the wound (symptoms of infection). -Wound #6 was documented as an unknown wound type to the right shin below wound #2 and was acquired during the resident's admission at the facility. It was indicated as not healing, measured 2.0L, 1.9W, and .1D cm, was beefy red in color, tender to touch, had jagged edges and had moderate amounts of serosanguineous drainage (symptoms of infection). -Wound #7 was documented as an unknown type of wound to the right shin below wound #6 and was acquired during the resident's admission at the facility. It was indicated as not healing, measured 2.0L x 1. 5W X .1D cm, was beefy red in color, dry, macerated, and had moderate amounts of serosanguineous drainage (symptoms of infection). -Wound #8 was documented as an unknown type of wound to the right shin and to the right of wound #6 and #7 and was acquired during admission. It was not healing, measured 1.0L x 1.3W x .1D cm, beefy red in color, macerated, and had moderate amounts of serosanguineous drainage (symptoms of infection). -Wound #9 was documented as an unknown wound type to the left second toe and was acquired during the resident's admission to the facility. It measured .6L x .9W x.1D cm and had a small amount of serous drainage. Resident #3 admitted to the facility with four venous stasis ulcers. During his stay, three of the four wounds worsened by increasing in size or developing signs and symptoms of infection. He acquired five additional wounds during his stay at the facility. According to the documentation provided by the home health company on 2/8/22 at 4:01 p.m. the home health nurse contacted the facility to provide information regarding the care the resident received while at the facility. The nursing note revealed the resident informed the home health nurse the facility never looked at or treated the wounds on his lower extremities. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility was notified by the home health nurse that a dressing which covered the wound to the second left toe was left on for the resident's entire stay and was removed by the home health nurse when the resident returned home from the facility. The home health nurse reported to the NHA that the resident had four wounds upon his admission to the facility, which were not treated and three of which had worsened. The home health history and physical, which was provided to the facility upon admission, documented the resident had existing wounds. The facility failed to complete a skin assessment upon the resident's admission to the facility and throughout Resident #3's stay. The facility failed to ensure the resident's existing wounds were treated and monitored. This resulted in wounds worsening during the resident's stay at the facility. 4. Staff interviews The director of nursing (DON) and NHA were interviewed on 2/9/21 at 12:30 p.m. The DON said skin assessments should be completed upon admission, weekly and as needed for all residents. She said the facility called skin assessments, skin checks. The DON said skin checks should be completed by a licensed nurse, the resident's entire body surface should be visualized by the nurse, and should encompass the entire body from head to toe to identify skin concerns. She said if a new wound or skin concern was found during a skin check, the nurse should notify the physician and obtain treatment orders. She said newly identified wounds should be referred to the wound physician, who rounded at the facility weekly. The DON said all wounds should have treatment orders and should be included on the resident's plan of care. The NHA said the resident was admitted prior to her starting at the facility. The DON said she was on vacation during Resident #3's respite stay, but an interim NHA completed the investigation. The DON reviewed the investigation, which concluded the resident did not have wounds. She confirmed she did not interview the nurses or complete the investigation. She confirmed she had not laid eyes on the resident's skin to have first hand knowledge of the resident's skin. The DON said upon discharge the nurse attempted to set up a wound consult as Resident #3 had weeping wounds. She said she was not sure how the investigation concluded the resident did not have any wounds, when the discharge documentation included a request for wound care due to the resident's weeping wounds. The DON confirmed the facility did not identify the resident's existing wounds, monitor the wounds or provide treatments for the existing and newly acquired wounds during the resident's respite stay at the facility. 45889 III. Failure to obtain treatment orders for Resident #19 A. Resident status Resident #19, age 89, was admitted on [DATE]. According to the February 2022 CPO, the diagnoses included difficulty walking, muscle weakness, cognitive communication deficit, personal history of transient ischemic attack and cerebral infarction without residual deficits, unspecified dementia, and type 2 diabetes mellitus. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 1/31/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. He required supervision with setup assistance for bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing. B. Record review The anticoagulation medication use care plan, revised on 7/25/21, revealed the resident was at risk for injury or complications due to the resident's use of anticoagulation medication therapy. The interventions included a comprehensive skin assessment that would be conducted weekly and to observe the resident for bleeding. The skin integrity care plan, revised on 10/27/21, revealed the resident was at risk for skin breakdown due to weakness and debility, dementia, incontinence, and history of melanoma. The interventions included to provide treatments to skin tears according to physician orders, observe for signs of infection until healed and report changes and the use of arm protectors as ordered by the physician. It indicated the resident had wounds on his coccyx and left forearm. The 2/6/22 skin check documented that no skin injury or wound was identified. -However, according to the observations starting on 2/1/22, the resident had multiple dark red dried spots of blood on his shirt. C. Resident observations and interview On 2/1/22 at 3:20 p.m., Resident #19 was observed wearing a blue denim button down shirt with multiple dark red dried spots of blood on the left sleeve of the resident's shirt. On 2/3/22 at 10:22 a.m. Resident #19 was observed wearing the same blue denim button down shirt. The spots of dried blood were still observed on the left sleeve of the resident's shirt. On 2/7/22 at 12:26 p.m. Resident #19 was observed wearing the same blue denim button down shirt with the spots of dried blood still present on the left sleeve. On 2/7/22 at 1:57 p.m. Resident #19 said he had a sore on his arm. He said he was not sure how or what date it happened. He pulled up the left sleeve of his blue denim button down shirt and a skin tear was observed to the left forearm, approximately 1 cm (centimeter) by 1 cm covered with dark red dried blood. On 2/8/22 at 8:50 a.m. Resident #19 was observed wearing a different shirt, which was observed to be clean. -Resident #19 was able to pick out his own clothes, but the staff were to put them out for him. He was observed above with the same shirt on, on four different days over the course of six days. D. Staff interviews (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Certified nurse aide (CNA) #6 was interviewed on 2/8/22 at 9:25 a.m. She said Resident #19 dressed himself. She said the staff set out clothes for him every day. CNA #6 said the resident had a skin tear on the left forearm. She said she would report it to the nurse. Licensed practical nurse (LPN) #2 was interviewed on 2/8/22 at 9:29 a.m. She said Resident #19 had a shower that morning with CNA #5. She said she had not received a report that Resident #19 had a skin tear on the left forearm. LPN #2 said she would observe the skin tear, start the change of condition assessment, notify the resident's family and physician, and provide treatment to the skin tear. CNA #5 was interviewed on 2/8/22 at 2:05 p.m. CNA #5 said she assisted Resident #19 with his shower that morning. She said she did not see a skin tear on his left forearm. She said she had helped the resident shower and dress. CNA #5 said any change of condition should immediately be reported to the nurse. Registered nurse (RN) #1 was interviewed on 2/9/22 at 11:22 a.m. RN #1 said skin assessments were completed as assigned on the user-defined assessment (UDA) list (in the resident's electronic medical record), which was usually upon admission, weekly and as needed. RN #1 said she preferred completing the assessment when the resident was in the shower or personal hygiene was being performed by the CNA so she would be able to see the resident's entire body and have help to reposition the resident. RN #1 said the resident should be visualized from top to bottom including the head, back, chest, arms, bottom and all the folds, legs, ankles, heels, toes and in-between the toes. She said she remembered completing the skin assessment for Resident #19 on 2/6/22. RN #1 verified she documented that there were no injuries or wounds found at that time. RN #1 said she remembered seeing the blood on the resident's shirt. She said she remembered seeing the skin tear on the resident's left forearm. She said she forgot to document it on the skin assessment. She said she should have completed the change of condition assessment, documented the skin tear, notified the resident's family and physician and obtained treatment orders to provide care for the resident's wound. She confirmed after she saw the resident's skin tear she did not provide a treatment. The director of nursing (DON) and NHA were interviewed on 2/9/22 at 12:30 p.m. The DON said skin assessments were completed upon admission, weekly and as needed by a licensed nurse. She said the nurse should look for and document any new skin concerns for the resident. The DON said that if there were any new issues, the resident would be assigned to wound care if needed. She said that any new wound or skin concern should be reported to the resident's representative/family and the physician and obtain treatment orders. The DON said she would provide education to the nursing staff to complete skin checks timely and thoroughly. She said she would perform a skin sweep throughout the entire facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43525 Based on observations, record review and interviews, the facility failed to ensure one (#6) out of 24 residents with limited range of motion received appropriate treatment and services. Specifically, the facility failed to for Resident #6: -Consistently provide restorative nursing services as ordered by the physician; -Update the care plan with the resident's most current restorative needs; and, -Apply the resident's splint to his pinky finger which was contracted. Findings include: I. Facility policy and procedure The Restorative Nursing policy and procedure, revised June 2021, was provided by the nursing home administrator (NHA) on 2/10/22 at 9:00 a.m. It read in pertinent part, Centers may provide restorative nursing programs for patients who: are admitted with restorative needs, but are not candidates for formalized rehabilitation therapy; have restorative needs arise during the course of a longer term stay; will benefit from restorative programs in conjunction with formalized rehabilitation therapy. Restorative programs are coordinated by nursing or in collaboration with rehabilitation and are patient specific based on individual patient needs. A registered nurse or licensed practical nurse must supervise the activities in a restorative nursing program .Develop restorative nursing programs appropriate to the patient's identified needs . Implement the restorative nursing program according to the specifics on the care plan. II. Resident #6 A. Resident status Resident #6, age 58, was admitted on [DATE] and readmitted on [DATE]. According to the January 2022 computerized physician orders (CPO), the diagnoses included multiple sclerosis (disease with nerve damage to the brain and spinal cord), flaccid hemiplegia (paralysis of one side of the body), contracture and functional quadriplegia (paralysis of all four limbs). The 1/4/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required extensive assistance of two people with transfers, bed mobility, dressing, personal hygiene and toileting, and extensive assistance of one person with eating. He received three days of passive range of motion and four days of splint and brace assistance during the assessment period. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Observation On 2/7/22 at 1:00 p.m., Resident #6 was observed laying in bed watching television. His left pinky finger was contracted, almost touching the palm of his left hand. He was not wearing a splint on the pinky finger. On 2/8/22 at 9:43 a.m., Resident #6 was observed laying in bed watching television. He did not have a splint on the pinky finger. His left pinky finger was almost touching the palm of his hand. On 2/9/22 at 10:12 a.m., Resident #6 was observed laying in bed watching television. He did not have a splint on the pinky finger. His pinky finger was in the same position. B. Resident interview Resident #6 was interviewed on 2/7/22 at 1:00 p.m. He said the restorative nursing program at the facility was terrible and there was no program. He said the restorative nursing aides (RNA) had been working as certified nursing assistants (working on the floor as certified nurse aides to provide care instead of completing restorative programs). He said the staff were supposed to move his feet around, put a foot drop brace on his ankle, put a pinky finger brace on his left hand, as his pinky had started to retract. He said the pinky finger on his left hand had been contracted for about six to eight months now. He said not all the CNAs knew how to put the splints and braces on correctly. He said it had been at least a month since the RNAs had come and put braces and splints on for him. He said he would tell the licensed nurses, but was told the facility was short staffed so the RNAs would get pulled to work as CNAs. He said he could tolerate his prescribed restorative program every day. He said he requested to receive his restorative program as many days as possible. On 2/8/22 at 9:43 a.m., Resident #6 said the CNAs would not put the splint on for him unless he asked. He said he was told it was not really their job. He said he was waiting for the CNA to come to the room and provide incontinence care before asking the CNA to help him put the splint on that morning. C. Record review The restorative splint and brace care plan, initiated on 1/31/2020, revealed the resident could not apply and remove the splint/brace due to functional deterioration. The interventions included to evaluate the resident's skin before the splint application and upon removal, to check for signs of skin irritation, restorative aide will provide verbal cues to prompt the resident and the restorative aide would set up equipment and supplies. The functional mobility care plan, initiated on 6/26/18, revealed the resident was at risk for alterations in functional mobility related to contracture deformity, diagnosis of multiple sclerosis, and functional quadriplegia. He had a history of declining to work with the restorative program. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interventions included to encourage activities which do not depend on dexterity, monitor for pain and stiffness, provide medication as ordered, observe for facial grimaces, moaning, guarding, which may indicate pain, obtain PT (physical therapy) /OT (occupational therapy) evaluation as indicated, and ROM (range of motion) as tolerated with the restorative program. The restorative range of motion active and passive care plan was initiated on 3/22/18. It revealed Resident #6 demonstrated loss of range of motion related to functional deterioration. The resident often declined to work related to being tired or not wanting to do anything. The resident was approached at different times of the day and revisited frequently in hopes of better timing but he was often still unwilling to do restorative programs, and declined to get up in the wheelchair for activities or ROM exercises. The restorative care plan was updated on 1/26/21. It indicated the resident was doing well and enjoyed being able to participate in the restorative program. The goal included to prevent contractures and maintain his skin integrity. -The facility failed to update the care plans to include Resident #6's left pinky finger contracture or a detailed restorative nursing program to address the left pinky finger contracture. The February 2022 computerized physician order (CPO) revealed the following physician's orders: -To participate in a restorative nursing program for passive range of motion and splinting as tolerated-ordered on 1/31/2020; and, The restorative program for passive range of motion and the splint/brace assistance documentation revealed: For October 2021, Resident #6 received restorative services a total of 18 out of 31 days on 10/1/21, 10/2/21, 10/5/21, 10/7/21, 10/9/21, 10/10/21, 10/13/21-10/17/21, 10/19/21-10/23/21, 10/27/21 and 10/31/21. -There were no resident refusals documented. For November 2021, Resident #6 received restorative services for a total of 18 days out of 30 days on 11/4/21-11/8/21, 11/11/21-11/14/21, 11/17/21-11/20/21, and 11/24/21-11/28/21. -There were no resident refusals documented. For December 2021, Resident #6 received restorative services for a total of 18 days out of 31 days on 12/2/21-12/4/21, 12/6/21, 12/8/21-12/11/21, 12/14/21-12/18/21, 12/20/21, 12/22/21- 12/25/21 and 12/29/21. -There was no resident refusal documented. For January 2022, Resident #6 received restorative services for a total of 14 days out of 31 days on 1/2/22, 1/4/22, 1/6/22-1/12/22, 1/23/22, 1/24/22, and 1/26/22-1/28/22. -There was no resident refusal documented (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 2/1/22-2/7/22, Resident #6 did not receive any restorative services. D. Staff interview CNA #6 was interviewed on 2/8/22 9:10 a.m. She said she helped Resident #6 put a splint to his pinky finger. She would leave the splint on for two hours. She said it was the therapists job but had not been doing it so Resident #6 would ask the CNAs to do it. She said the occupational therapist trained her how to put the splints on. The clinical reimbursement coordinator (CRC) was interviewed on 2/8/22 at 9:33 a.m. He said the restorative program was developed in collaboration with the director of rehabilitation, RNA, and staff input. He said the program, throughout the entire facility, was currently put on hold since the RNAs were not available. He said the RNAs were working as CNAs on the floor to assist with staffing. He said the RNAs being pulled to the floor happened more during covid a outbreak. He said when there was a staffing shortage, nursing care would be prioritized over restorative therapy. He said he encouraged the RNAs to continue the restorative program with their assigned resident when working as CNAs. He said the CNAs should work the RNA program into each resident's daily routine. RNA #1 was interviewed on 2/9/22 at 9:21 a.m. He said he was taken off his restorative nursing duties due to staffing needs. He said it happened more often during a COVID-19 outbreak period. He said about 75 percent of the time he would be pulled to work as a CNA. He said it had been happening for over six weeks. He was scheduled that day as an RNA, but when he arrived he was pulled to the floor to work as a CNA. He said he worked as an RNA for a little bit this past Sunday, but the other RNA was pulled to work as a CNA the entire week last week. He said he did not have time to do restorative therapy for his assigned resident when working as a CNA. He said Resident #6 was still on the restorative program list. He said the resident's pinky finger contracture was newer. He said the facility got a splint for him to prevent further worsening of contracture. He said the resident could tolerate the pinky finger splint for up to six hours a day. He said the CNAs had been trained on how to put the splints and braces on for him, but Resident #6 usually preferred the RNA or the therapist to apply the splint. The director of nursing (DON) was interviewed on 2/9/22 at 12:30 p.m. She said pulling the RNAs to the floor to work as CNAs should be the last resort. She said the RNAs were typically used as CNAs during COVID-19 outbreaks. She said the RNAs could still help with residents' restorative needs even when they were working on the floor. She said each resident should receive their RNA services as ordered by the physician. She said RNA services were important in maintaining and attaining each resident's highest practicable well-being. She said the CNAs should provide the RNA program to each resident when the RNAs were pulled to the floor.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, interviews, and record review, the facility failed to ensure one (#13) out of 24 sample residents. Specifically, the facility failed to ensure documented interventions were implemented while the resident was actively exhibiting behaviors of yelling out to ensure the resident attained and maintained her highest practical well-being and Resident #13's behaviors did not interfere with other residents. Findings include: I. Policy and procedure The Behavior Management of Symptoms policy and procedure, revised on 10/1/21, was provided by the nursing home administrator (NHA) on 2/10/22 at 9:00 a.m. It revealed, in pertinent part, Patients exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to changes in the patient's behavior. Based on the comprehensive assessment, staff must ensure that a patient: Who displays or is diagnosed with mental disorder or psychosocial adjustment difficult reviews appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Staff will use non-pharmacological interventions as the first line of approach to managing challenging behaviors. Behaviors and interventions will be addressed in the care plan. II. Resident #13 status Resident #13, age 68, was initially admitted on [DATE] and readmitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included: gastroesophageal reflux disease (GERD), gout, hypertension, type two diabetes mellitus (DM2), morbid obesity, depression, chronic kidney disease (CKD), and dementia. The 9/15/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. She required extensive assistance of two people for bed mobility, transfers, toileting and extensive assistance of one person for dressing and personal hygiene. The resident had verbal behavioral symptoms directed toward others and not directed towards others for one to three days during the assessment period. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident had no episodes of rejecting care. A. Observations On 2/1/22 at 2:26 p.m. Resident #13's door to her room was closed. During a continuous observation on 2/3/22 beginning at 10:27 a.m. and ended at 10:59 a.m. the following was observed: -At 10:27 a.m., Resident #13 was in her bed with the door closed. The resident began yelling out help, I need somebody. -Two staff members were observed two rooms down the hallway cleaning up a spill as Resident #13 continued to yell out for help. The staff members did not address the resident's call for help. -At 10:37 a.m. an unidentified certified nursing aide (CNA) entered Resident #13's room and asked the resident if she needed anything. The resident was unable to verbalize what she needed. The CNA did not implement any of the documented interventions on the resident's plan of care. Shortly after the CNA left the resident's room, Resident #13 began yelling: help me, I need food, I need help. -The CNA re-entered Resident #13's room and asked how they can help her. The resident responded that she needed some canned food to store in her room for when she is hungry. The CNA let the resident know that the facility had food to give her for meals, but did not offer her any snacks, which was a documented intervention on the resident's plan of care. (see record review below) On 2/7/22 at 9:15 a.m. Resident #13 was in her room with the door closed. -At 2:45 p.m. and 4:49 p.m., Resident #13 was observed in her room yelling out for help. The facility staff did not enter the resident's room to assist the resident. During a continuous observation on 2/8/22 beginning at 8:53 a.m. and ended at 10:14 a.m. the following was observed: -Resident #13 was in her room with the door closed, yelling out for help and said she was scared. An unidentified CNA entered the residents room and said good morning and told the resident she was alright and left the resident's room. Resident #13 was observed seated in her wheelchair. Shortly after, the CNA left the residents room, Resident #13 began yelling for help again. -At 10:07 a.m. an unidentified CNA walked past Resident #13's room as she was yelling for help. The CNA did not enter the room to assist the resident. -Another unidentified CNA entered the resident's room a few minutes later and asked if the resident needed anything. She did not implement any of the documented interventions on the resident's plan of care. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/8/22 at 10:45 a.m., Resident #13 was yelling, help me, I need help. A CNA was observed walking by the resident's room in the hallway. Under her breath, the CNA said, ok, honey. The CNA did not enter the resident's room or offer the resident any assistance. During a continuous observation on 2/8/22 beginning at 11:40 a.m. and ended at 11:51 a.m. the following was observed: -Resident #13 yelled for help, which could be heard at the nurses station. Multiple staff members were observed sitting at the nursing station. The facility staff did not go and check on the resident. -CNA #1 walked down the hallway. Resident #13 yelled out for help. CNA #1 shook her head and grabbed the mechanical lift to transfer the resident to bed. CNA #1 entered the resident's room and offered to lay Resident #13 down in bed. The resident agreed and CNA #1 left the room to get another staff member for help. CNA #1 returned to the resident's room with another CNA. Resident #13 refused to be laid down in bed and wanted to stay in her wheelchair. B. Resident #21's interview Resident #21 was interviewed on 2/8/22 at 10:30 a.m. Resident #21 said Resident #13 yelled all day and night. He said she always yelled out for help. He said she would yell at 4:00 a.m. He said Resident #13's yelling kept him awake at night. C. Record review The behavioral care plan, initiated on 7/6/21 and revised on 11/16/21, revealed Resident #13 had exhibited problems with self-management and self regulation, which result in the resident being socially inappropriate related to having a mental illness, dementia-related illness, physical discomfort/pain/distress, agitation, depression, diminished ability to express, verbalize needs/feelings, communicating anxiety; and being restless, vulnerable, and powerless. The resident frequently called out for help. The interventions included: to assess the resident for pain, to develop an activity plan of care centered around the residents interests, to evaluate and treat mood distress, to invite the resident to church services, to involve the resident in supportive mental health interventions, to use frequent reassuring phrases, to implement non-pharmacological interventions (turn on the television to the western channel, turn on the radio to latin/hip hop station, paint her nails, provide a hand massage, talk about baking or gardening, read the bible, offer snacks, take outside, turn on the sound machine, call her son, or escort her to activities). (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another behavioral care plan was initiated on 10/6/2020 and revised on 7/6/21, revealed Resident #13 exhibited verbal behaviors. The interventions included: to offer non-pharmacological interventions (turn the television to the western channel, turn the radio to the latin/hip hop channel, paint her nails, provide a hand massage, talk about baking or gardening, read the bible, offer snacks, take her outside, turn on the sound machine, utilize the essential oils diffuser, call her son, or escort her to activities), to monitor medications, to evaluate the nature and circumstances of the behavior, to evaluate the need for a psychology consultation, and to remove the resident from the environment. The activities care plan, initiated on 11/6/19 and reviewed on 7/6/21, revealed Resident #13 was legally blind, needed assistance from staff to take her to activities. The resident enjoyed snacks, music, watching Westerns on the television, listening to the radio, getting her nails painted, going outside, resting in bed with her sound machine, talking about baking, and Bible study. The interventions included: to provide one on one visits with the resident, offer church services, offer to paint her nails and provide a hand massage, offer to take her outside, offer to turn a western on the television, offer to turn on the radio or sound machine, provide books on tape, encourage participation in group activities, offer snacks, and provide coloring materials. A review of the resident's electronic medical record on 2/7/22 at 2:30 p.m. revealed the resident was seen by a licensed clinical social worker (LCSW) for counseling sessions on 8/12/21, 8/19/21, 12/16/21, 12/20/21, and 12/27/21. The therapy progress notes from the LCSW documented that the resident said she was fearful and lonely, which caused her to yell out for help. She said if someone spent time with her she would have felt more comfortable. A review of the previous 30 days of behavior tracking revealed the resident had verbal outbursts daily. The 1/11/22 nursing progress note documented the resident slept most of the day, but started screaming help around 5:00 p.m., which the nurse checked on her. The nursing note did not include whether or not the nurse provided interventions to address the resident's behavior. The 1/2/22 nursing progress note documented the resident was hollering and would only be consoled if a staff member spent time with the resident. III. Staff interviews CNA #8 was interviewed on 2/8/22 at 10:08 a.m. She said she had worked with Resident #13 for a few shifts. She said she was not aware of any interventions that would help the resident calm down. She said she did not review the resident's care plan. She said the staff used word of mouth to identify interventions that worked for each resident. CNA #1 was interviewed on 2/8/22 at 10:15 a.m. He said Resident #13 had frequent behaviors of yelling out. He said the staff try to offer music, snacks, beverages, or laying down to help prevent the yelling. He said nothing helps her behavior. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was interviewed on 2/9/22 at 9:54 a.m. She said when a resident had behaviors she tried to provide redirection. She said sometimes interventions were documented in the care plan to help with residents' behaviors. LPN #1 said Resident #13 yelled on and off throughout the day. She said calling her family or bringing her into the hallway were techniques that helped Resident #13's behaviors. She said Resident #13 enjoyed sitting near the nurses station. The NHA and the director of nursing (DON) were interviewed on 2/9/22 at 12:30 a.m. The DON said if a resident was having behaviors the nursing staff were responsible for assessing the situation to see if the resident needed help. She said a lot of the residents at the facility yelled out for help and did not realize it. The DON said Resident #13 frequently yelled out for help. She said Resident #13 enjoyed having people around her, having music playing, drinking coffee, church services and getting her nails painted; which helped control the residents' verbal outbursts. She said Resident #13 was legally blind and being around people helped with making her feel safe. She said when the resident was brought to the nursing station, it usually helped with her behavior of yelling out for help. She said behavioral interventions were documented on the resident's care plan. She said the nursing staff was responsible for implementing interventions that were documented on the care plan to help with the residents' behaviors.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43525 Based on observations, record review and interviews, the facility failed to meet the nutritional needs of the residents in accordance with established national guidelines for three out of five diets served. Specifically, the facility failed to: -Follow the menu approved by a registered dietitian (RD), and inform residents and RD of menu changes in advance; -Follow the portion sizes specified on the menu extension; and, -Provide a protein substitute for Resident #22 to replace the main entree protein. Findings include: I. Failed to follow the menu approved by a registered dietitian (RD), and inform residents and the RD of menu changes A. Observations On 2/3/22 at 12:25 p.m., two residents in room [ROOM NUMBER] were observed in their room. Both residents complained about their lunch trays in the room. Resident in bed B had a stack of enchiladas on his plate that were dry and overcooked with dark brown curled tortilla edges. He said would you eat that? and said he refused to eat it. He said spaghetti was on the menu for the lunch meal. The resident in bed A had a stack of enchiladas that was pureed in consistency and a scoop of refried beans that was dry and overcooked with a crusty top on the refried beans. He said he refused to eat it. -At 12:47 p.m., Resident #3 in room [ROOM NUMBER] got his lunch meal and said this is not what I was supposed to get. He came out of the room and told a certified nursing aide (CNA) that he did not get what was on the menu. The CNA said he would go check the kitchen to get the right meal. -At 12:56 p.m., Resident #3 told the nurse that this was not what he requested for lunch and that his food was cold and dried up. Resident #3 said he was told he was getting spaghetti and that the CNA said he was going to replace it for him but did not come back. -At 1:00 p.m., the nurse came to Resident #3 and said that spaghetti was not on the menu. She said I got you a new lunch that is warm. Activities must have had the menu wrong because spaghetti was never on the menu. -At 1:04 p.m. Resident #3 said this was so (expletive) to himself while consuming his meal. -At 1:20 p.m., Resident #3 spoke to someone on the phone that it was the worst lunch he has ever had. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 1:25 p.m., the menu posted on the 600 unit documented the lunch meal was spaghetti, caesar salad, dinner roll, vanilla ice cream or roasted pork, spinach, garlic potatoes, and breadstick. B. Record review The Week At A Glance menu week one revealed Thursday, 2/3/22, the lunch for regular and alternate meal were: Spaghetti with tomato meat sauce and parmesan cheese, caesar salad with homemade croutons, breadsticks, two percent milk and assorted beverages. The alternate entree was rosemary roasted pork loin with parsley garnish, italian dinner roll, garlic seasoned potatoes, two percent milk and assorted beverages. The week at a glance menu week two revealed Tuesday 2/8/22 lunch for regular and alternate meal were: Ritz butter baked fish, grapes, seasoned peas, dinner roll, scalloped potatoes, two percent milk and assorted beverages. Alternate entree was honey glazed chicken one each, sliced carrots, dinner roll, scalloped potatoes 1/2 cup, two percent milk and assorted beverages. The 11/18/21 registered dietitian monthly sanitation audit report was provided by the nursing home administrator (NHA) on 2/8/22 at 1:14 p.m. It documented that the menu board was not updated consistently. It indicated many residents complained that the food they received did not match what was being printed on the Daily Chronicle, which was given out daily by activities. The changes were not reflected on the Daily Chronicles and it was confusing to many residents. C. Staff interviews The dietary account manager (DAM) was interviewed on 2/8/22 at 11:20 a.m. She said any changes to the menu should be added to the menu substitution log for RD approval. She said last Thursday's (2/3/22) lunch was changed because of the Friday celebration schedule National Wear Red Day. She changed the menu on Thursday to enchiladas and Friday to chicken cacciatore so there would not be two pasta dishes that were one day apart from each other. The DAM said she did not write down the changes on the menu substitution log for the RD to review because she did not know it was required. She said she did not make the menu changes in the computer meal tracker program so accurate menus could be printed on resident's tray tickets. The lead dietitian (LD) was interviewed on 2/9/22 at 10:38 a.m. She said menu changes that required an equivalent substitution should be noted on the substitution log. She said the dietitian should review all menu changes at the next visit. She said the changes should be reflected on the daily menu board and the residents should be informed of the change. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The recreation assistant (RA) #1 was interviewed on 2/9/22 at 9:50 a.m. She said the daily lunch and dinner menus were printed on the Daily Chronicle because many residents did not leave their rooms and were unable to check the menu board. She said if she was not informed of menu changes in advance, the changes would not be reflected on the Daily Chronicle. RA #1 said she often assisted residents with menu selections if residents wanted the alternate entree instead of the regular entree. She said she would circle the alternate entree for the residents and submit the selection to resident's nurses or directly to the kitchen staff, but it was often not followed. RA #2 was interviewed on 2/9/22 at 9:52 a.m. He said he printed The Daily Chronicles last Thursday. He said he did not know the menu had been changed. He confirmed that spaghetti with meat sauce was printed on the Daily Chronicle, instead of the enchilada. II. Failed to follow the portion sizes specified on the menu extension A. Observations During the lunch meal on 2/8/22 beginning at 12:05 p.m. and ending at 12:54 p.m., Cook #1 used a #12 scoop (1/3 cup) for scalloped potatoes for all diets and a #20 scoop (2 ounce, oz) to serve ground fish. B. Record review The #12 scoop (1/3 cup), measuring 2.67 oz, was 1.33 oz less than the 1/2 cup (4oz) specified on the menu extension sheet for the scalloped potatoes. The #20 scoop, measuring 2 oz, was 1.32 oz less than the #10 scoop (3.2 oz) specified on the menu extension sheet for the fish. The 2/8/22 lunch menu extension revealed portion sizes for regular liberalized diet was: Ritz butter baked fish one each, grapes 1/2 cup (#8 scoop), two percent milk four oz, seasoned peas 1/2 cup (#8 scoop), dinner roll one each, scalloped potatoes 1/2 cup (#8 scoop). Alternate entree was honey glazed chicken one each, sliced carrots 1/2 cup, dinner roll one each, scalloped potatoes 1/2 cup. The consistent carbohydrate diet (CCHO) revealed the portion size for scalloped potatoes was 1/3 cup (#12 scoop). All other food portions were the same as the regular diet. The regular liberalized dysphagia advanced diet revealed ground meat ritz butter baked fish should be #10 scoop instead of #20 scoop, applesauce 1/2 cup, two percent milk four oz, seasoned peas 1/2 cup, dinner roll one each, scalloped potatoes 1/2 cup. C. Staff interviews (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The general manager (GM) was interviewed on 2/8/22 at 12:54 p.m. She reviewed the menu extension for dysphagia advanced fish and scalloped potato for the different diets. She said dysphagia fish should be #10 scoop and scalloped potatoes should be 1/2 cup for the regular and 1/3 cup for the CCHO diets as printed on the extension. She confirmed that Cook #2 used incorrect scoop sizes for dysphagia advanced fish and scalloped potato for regular and regular dysphagia diets. III. Failed to provide a protein substitute for Resident #22 to replace the main entree protein A. Observations On 2/8/22 at 12:26 p.m. Cook #1 plated Resident #22 lunch tray with scalloped potatoes and peas. She did not put fish or chicken on the plate. Cook #1 paused to read the tray ticket and spoke to the dietary aide next to her. She said the resident had a fish allergy and did not like chicken. She said there was no other protein printed on the ticket. She covered the resident's lunch tray and placed it in the meal delivery cart. B. Staff interview The GM was interviewed on 2/8/22 at 12:54 p.m. She said if a resident was allergic to fish and did not want chicken, another meat substitute should be provided. She said she was not sure why a meat substitute was not automatically populated on the tray ticket. The LD was interviewed on 2/9/22 at 10:38 a.m. The LD was unsure why the tray ticket did not print a meat substitute for Cook #1 to follow. She said there should always be a substitute to replace the protein option when the main entree and alternate entree protein were not the preferred choice.

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	065232	A. Building B. Wing	02/09/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43525 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and service food in a sanitary manner in the kitchen. Specifically, the facility failed to: -Ensure the kitchen was free of pests; -Ensure kitchen equipment, food service, storage and preparation areas were maintained in a clean and sanitary manner; -Ensure food products and serviceware were stored in a sanitary manner to prevent cross contamination; -Ensure foods were labeled and dated correctly; and, -Ensure staff practice safe thawing, cooling procedures and food temperature monitoring. Findings include: I. Failed to ensure the kitchen was free of pests A. Facility policy and procedure The Pest control policy and procedure, revised September 2017, was provided by the nursing home administrator (NHA) on 2/8/22 at 4:02 p.m. It revealed, in pertinent part, all food preparation, service and storage areas will be monitored regularly for any signs of pest/vermin. The center staff will be notified immediately of any concerns . B. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, retrieved on 2/14/22, revealed in pertinent part, The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by routinely inspecting incoming shipments of food and supplies; routinely inspecting the premises for evidence of pests; using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12, 7-206.12, and 7-206.13; and eliminating harborage conditions. C. Observations (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the kitchen walkthrough with the general manager (GM) on 2/3/22 at 10:39 a.m, one sticky cockroach trap was found next to two bulk food bins. The trap had three dead cockroaches that were one to 1.5 inches in size. During the meal preparation observation on 2/8/22 beginning at 10:20 a.m. and ended at 12:05 p.m., the following were observed: At 10:46 a.m., morning cook (Cook #1) was breading fish for lunch service at the food preparation counter. One live cockroach that was brown in color and about two inches in size, came out from the metal covering next to the spice shelf directly above the food preparation counter. Cook #1 attempted to kill it with a glove but missed, the cockroach went back inside the metal covering by the spice counter. At 10:55 a.m., the cockroach came out from under the metal covering again and Cook #1 killed it with a glove, then discarded it in the trash bin. At 11:02 a.m., another brown cockroach that was about one inch in size came out from the back of the food preparation table. Cook #1 killed it with a glove and discarded it in the trash bin. There were six sticky cockroach traps inside the chemical closet that was located outside of the kitchen, adjacent to the dining room and the room with an ice machine and resident's refrigerators. Four out of the six traps had dead cockroaches inside. D. Staff interviews The GM was interviewed on 2/3/22 at 10:39 a.m. The GM said the kitchen had pest concerns for a few months and had pest control servicing more frequently. She said the pest control company would remove the old traps during their next visit. The kitchen staff did not need to remove the traps even if there were cockroaches inside. The dishwasher (DW) was interviewed on 2/3/22 at 12:07 p.m. He said he saw more cockroaches from July to September 2021, lately it had been better. On 2/8/22 at 12:04 p.m., the DW said he had seen cockroaches on the food trays. He had reported the concern to the previous NHA last year but was told bugs didn ' t exist. When he saw cockroaches, he would report it to the kitchen manager. Cook #1 was interviewed on 2/8/22 at 10:46 a.m. She said last year the whole chemical closet was infested with cockroaches but it had improved recently. She said she usually saw them in the dishwashing area in the morning. She would kill them with gloves if cockroaches were still alive. The preparation cook (Cook #2) was interviewed on 2/8/22 at 11:05 a.m. Cook #2 said the cockroach problem was very bad about a month and half to two months ago. They would come in from the serving window by the steam table. He reported the concern to the kitchen manager verbally. The assistant manager (AM) of the kitchen was interviewed on 2/8/22 at 11:52 a.m., the AM said she notified the previous NHA but he did not do anything last summer. They changed to a different pest control company after numerous complaints from the kitchen staff. She said during the hot months she would see cockroaches on a daily basis everywhere, but not so much during the cold months. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The dietary account manager (DAM) was interviewed on 2/8/22 at 11:10 a.m. She said an outside pest control company had been coming to the facility two times per month since October 2021. She said she started working at the facility in October 2021, and according to the dietary staff, cockroaches had been a problem since before October. She said cockroaches would come out of the floor boards, by the door, when first entering the kitchen, the serving line and above the food preparation table on the spice shelf. She said she had not seen any cockroaches in the food. She said the cockroaches came out of the walls during different times of the day. She said if the dietary staff saw a cockroach, they should kill it and wash their hands. The maintenance supervisor (MS) was interviewed on 2/8/22 at 11:30 a.m. He said an outside pest control company came to the facility twice per month to address the concern of cockroaches in the kitchen. He said cockroaches were found primarily in the dishroom. He said if there was a spike in pests, the pest control company would come to the facility more often. The NHA and director of nursing (DON) were interviewed on 2/8/22 at 12:00 p.m. The NHA said all pest concerns should be reported to the maintenance department. She said the facility did not have a log or book to write down any pest concerns. She said the staff notified the maintenance department by word of mouth. She said the outside pest control company came to the facility twice per month. She said they had been focusing on the cockroach concern which was primarily in the kitchen. She said cockroaches had been seen in resident rooms and the central supply closet. The DON said in October 2021, she was aware cockroaches were found on resident meal trays, but had not heard or seen anything like that since. She said the facility had deep cleaned the kitchen and the tray boxes. She said the facility did take out meals for residents when that occurred in October 2021. The NHA said she entered the kitchen every day. She said they needed to work on the cleanliness in the kitchen, however it has improved since she starting working at the facility in October 2021. She said the facility needed to re-do the dishroom. She said they had already knocked down some of the walls because of the cockroach problem. She said they were waiting for approval to remove and install new flooring in the dishroom. The NHA said there was a hole beneath the dishmachine and that was how the cockroaches were getting into the facility. She said the plan was to tear up the flooring, repair the hole and then put new flooring down in its place. She said she hoped that would help take care of the cockroach problem. The NHA said she felt the lack of cleanliness in the kitchen added to the cockroach problem in the facility. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A telephone interview with the pest control company was conducted on 2/9/22 at 9:08 a.m. The pest control company (PCC) technician said he was at the facility last week. There were a couple of roaches in the trap inside the ice machine room. He said when the pest control service first started, he would see 30 to 50 roaches in the roach hotels per monitoring. He said the roaches used to be everywhere but now the main areas he targeted were the dishwashing room, the ice machine room and the maintenance room. The PCC said he was not informed of any sightings near the food preparation area or the steam table area. If the facility had reported to him, he could have used a different type of bait that was suitable near food. He said thereNHA was a logbook by the front desk that staff could use to communicate with the pest control technicians, but it was never filled out since he started. He said it would help if the facility filled out the log so he would know where to target for treatment. The PCC said he would recommend kitchen staff to take out trash nightly and the trash can should be covered, and any open food containers should be closed. He had seen overfilled garbage dumpsters in the parking lot a few times during his visit. He said if they did not do their part, it would not work. This was a team effort. The lead dietitian (LD) was interviewed on 2/9/22 at 10:38 a.m. She said dietitians helped with kitchen oversight by conducting monthly sanitation audits. It was completed once a month or more frequently as needed. She said the facility dietitian had identified pest problems on the sanitation audit in the past, and the report was sent to the account manager and district manager. They were aware of the cockroach concerns. E. Record review The pest control visit reports were provided by the NHA on 2/8/22 at 11:06 a.m. The reports revealed facility had pest control services twice a month on 9/23/21, 9/30/21, 10/11/21, 10/29/21, 11/18/21, 11/22/21, 12/7/21, 12/15/21, 12/27/21, 1/13/22, 1/26/22 and 2/7/22. The registered dietitian monthly sanitation audit report dated 11/18/21 was provided by the nursing home administrator (NHA) on 2/8/22 at 1:14 p.m. The checklist did not include areas to check for pests. The comment section did not have information about pests. II. Failed to ensure kitchen equipment, food service, storage and preparation areas were maintained in a clean and sanitary manner A. Facility policy and procedure The Environment policy and procedure, revised September 2017, was provided by the NHA on 2/8/22 at 4:02 p.m. It revealed, in pertinent part, The dining services director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lightening, and ventilations . The dining services director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces . All trash will be properly disposed of in external receptacles (dumpsters) and the surrounding area will be free of debris. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Professional resource The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, retrieved on 2/14/22, revealed in pertinent part, Equipment food-contact surfaces and utensils shall be clean to sight and touch. The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Non food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris . Non food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. C. Observations During the kitchen walkthrough on 2/3/22 beginning at 10:15 a.m. and ended at 12:30 p.m The following was observed: The floors under the dishwashing sink, handwashing sink, food preparation sink and the three compartment sink were dirty with grime and black residue buildup. There were several tile cracks in the dishwashing area resulting in dirty water, food debris and grime accumulation inside the cracked areas. One wash tray was stored directly on the dirty floor and rest of the wash trays were stored on the cart that had heavy food debris buildup around the inner corner of the cart. The floor drains under the dishmachine and food preparation sink were very dirty. There was a thick layer of black and brown residue buildup along the inner corner of the drains and on the drain covers. There were brownish splatters on the wall inside the dishwashing area. The top of the dishmachine had two large pieces of black dust and there were heavy yellow and brown debris build up on top of both sides of the dishmachine doors. The fan inside the dishwashing room had a thick layer of dust accumulated on the cover. The window sill by the food preparation counter next to the reach-in refrigerator had visible accumulation of dust and grime around the corners. There was a dusty goggle, gloves and an apron stored on top of the dusty window sill. The bottom shelf under the steamer had visible food debris and grease buildup. There was also food debris on the floor underneath the grill and the steamer. The ceiling and wall inside the walk-in refrigerator had several areas with visible black substance buildup. There was a large dust accumulation on the condenser fan. The freezer floor inside the walk-in refrigerator had black streaks and black residues buildup under the freezer shelf. There were visible cracks and holes on the bottom of the wall under the bulletin board outside of the pantry room and underneath the three compartment sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The wall under the spice counter had yellow and brown splatter and there was yellow debris encrusted on the outlet covers next to the blender. The spice shelf was dusty and was covered with spice particles. The steam table temperature dial knobs were dirty with visible yellowish debris encrusted around the knobs. D. Staff interviews The GM was interviewed during the kitchen walkthrough on 2/3/22 between 10:15 a.m. to 12:30 p.m. The GM said she saw all the dirty areas that were pointed out during the kitchen walkthrough. She said there was a cleaning schedule that indicated what area to clean on a daily and weekly basis. All floors, including those under shelving and inside walk-in refrigerator, should be sweeped and mopped on a daily basis. Fans in the dishwashing area and walk-in refrigerator should not have dust accumulation. She was unsure what the black spots and black streaks were inside the walk in refrigerator and freezer. She said maintenance should be informed about dusty fans and the floor cracks in the three compartment sink and dishwashing area. The DW andGM were interviewed on 2/3/22 at 11:09 a.m. He said the dish machine was deep cleaned and de-limed about once a week, he would wipe down the top of the machine and two doors weekly. The dust fell regularly from the vent above. The GM said dishmachine should be cleaned every shift, and staff should not wait for a week especially if it was visibly soiled. There should not be yellow debris building up on top of the dishmachine doors. E. Record review The cleaning schedule posted on the bulletin board revealed the daily cleaning task included: organize line cooler, wipe down coffee area, clean food carts, all dishes done and organize shelf, all dishes clean and put away, stainless shine, and sweep and mop floors. There were several gaps on the weekly deep cleaning schedule from 1/2/22 to 2/5/22. According to the staff signature and dates, deep cleaning occurred on the following days: -Oven was cleaned once on 1/11/22 -Range and back wall were cleaned once on 1/25/22 -Refrigerator and freezer purge and deep clean was done during the week of 1/30 to 2/5/22 but the exact date was not specified. -FOH (front of house) and organize condiment was done once on 1/23/22 -All drawers and bins were cleaned on 1/10 and 1/22/22 -Trash cans were not cleaned -Detail dish machine and all areas were not completed (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Deep clean all drink cart were not completed -Pull and wash hoods were not completed -Detail kitchen walls were done once on 1/13/22 -Detail floorboards, [NAME] and crannies were not completed -Clean and clear all windows and sills were not completed -Scrub dishroom floor and corners were not completed III. Failed to ensure food products and serviceware were stored in a sanitary manner to prevent cross contamination A. Facility policy and procedure The Food preparation policy and procedure, revised on September 2017, was provided by the NHA on 2/8/22 at 4:02 p.m. It revealed, in pertinent part, Dining services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use. B. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, retrieved on 2/14/22, revealed in pertinent part, Food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. C. Observation During the kitchen walkthrough on 2/3/22 beginning at 10:15 a.m. and ended at 12:30 p.m The following was observed: There were empty boxes and some trash stored in front of the bulk food bins, and the sticky pest trap that had three dead cockroaches was in the area where trash was placed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Clean bowls and clean utensils were drying in the wash tray and utensil racks on the dishwashing sink. However, there were used tissues, a dirty mug that had brown color stains, and eye goggles stored next to the clean utensil drying rack. The counter underneath the drying tray had cloudy water, food particles, lettuce debris and gunk build up along the side of the sink. The clean utensil drawer in the food preparation counter was lined with a layer of foil that had visible grease and food debris. A plastic container used to store clean food bin lids had a large crack and the inside of the container had visible food debris and crumbs. The grill had black burnt particles on top of the grill surface and breakfast leftover food debris , black grease was on the corner of the grill and the lower tray. It was not cleaned prior to the cooks making hamburger patties on the grill during lunch service. The bulk sugar and salt containers under the food preparation counter had a lot of white particles covering the lids and the exterior of the containers. The trays used to store the bulk containers and one box of bananas was filled with large amounts of white particles and food debris. Four bags of opened cereal that were not sealed in the cabinet above the food preparation table, and another three bags of hot dog buns were left open to air on the bread rack. The lower shelf of the food preparation counter was lined with a piece of foil that was visibly soiled with food debris, grease, and white color batter like substances. The were sheet pans, cooking bowls, and baking parchment paper stored on top of the soiled foil. The reach-in refrigerator inner door, shelving, and inner wall had visible food spills, and the thermometer inside was covered with food debris. Four food trays holding prepared foods and sauces were covered with visible food particles and sauces dripping. Two resident's refrigerators inside the ice machine room were dirty. The inner door shelf had yellow caked on debris, the trays used to store yogurt had brown color dripping and appeared sticky. The ice cream freezer above had black spots inside. There was a jacket and a personal bag placed on top of the box inside the pantry area by the food. D. Staff interviews The GM was interviewed during the kitchen walkthrough on 2/3/22 between 10:15 a.m. to 12:30 p.m. The GM said staff put trash and empty cardboard boxes by the bulk food bin area temporarily until they had time to go to the outside dumpster. She said it was not the best place to put trash because there were food products next to it. She agreed that trash and cardboard boxes left in the kitchen had a potential to attract pests. The GM confirmed the drying tray area was on the clean side of the dishwashing area, and said they should clean the area immediately to remove tissues, dirty cups and rinse the dirty water with food debris under the drying rack. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She said any food contact surfaces, containers and drawers used to store clean utensils or lids should be clean without debris. Any opened food products should be sealed after opening. The reach-in refrigerator was cleaned on a weekly basis, but it should be cleaned as needed or a quick wipe down if staff saw debris or dripping. She said personal belongings should not be in the food storage area, and they should be stored in the manager's office. IV. Failed to ensure foods were labeled and dated correctly A. Facility policy and procedure The Food preparation policy and procedure, revised on September 2017, was provided by the NHA on 2/8/22 at 4:02 p.m. It revealed, in pertinent part, All Time/temperature control for safety (TCS) foods that are to be held for more than 24 hours at a temperature of 41 F or less, will be labeled and dated with a prepared date (Day 1) and a use by date (Day 7). B. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, retrieved on 2/14/22, revealed in pertinent part, Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. Ready to eat, TCS food prepared and held in a c 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 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated ready to eat, TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded . The day the original container is opened in the food establishment shall be counted as day one; and 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. C. Observation During the kitchen walkthrough on 2/3/22 beginning at 10:15 a.m. and ended at 12:30 p.m The following was observed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Two containers of unknown sauces in the reach-in refrigerator without labels indicating its content. One sauce was dated 2/2 and one did not have a date. One container of egg salad in the reach-in refrigerator had a date label of 1/27, which was eight days after it was made. One opened bag of breadcrumb-like food in the pantry did not have a label indicating its content, nor a date indicating when it was received, opened or to be used by. Three bags of opened hot dog buns, one bag of opened hamburger bun, and five bags of opened breads did not have open or use-by dates. On the spice shelf, there were two poultry spice blends, chives, basil, nutmeg, italian seasoning, cinnamon, rosary and taco mix that did not have a receive, open or a use-by date. Inside the walk-in refrigerator, the following items did not have clear date and labels: -Two containers of unknown food products in the walk-in refrigerator. One had white milky color with green chunks inside and another one was white milky products made with macaroni pasta. Both containers did not have labels indicating its content, nor a prepared date or a use-by date. -One container of sliced strawberries had a written open date of 1/3 and a printed use-by date 1/10/22 on the container. -One container of rice dated 2/1 and one container of turkey with gravy dated 1/31. Both without a use-by date on the container. -One box of unopened tortilla did not have a received date or a use-by date. -One bag of lunch meat did not have a name label indicating its content. Inside the resident's refrigerators, the following items did not have clear dates or labels: -One container of unknown food content dated 1/31 and did not have a use-by date. -There were two cartons of health shakes without a date indicating when it was pulled from the freezer or when to use-by after thawed. -One container of half and half creamer had a printed use-by date of 1/17/22. D. Staff interviews The GM was interviewed on 2/3/22 at 10:28 a.m. She said all prepared food should be labeled with the food product's name and a date. Facility-made foods could be stored for up to seven days with day one starting on the day it was made. All food products should be dated when it was received, and an open date when it was opened. Foods should be discarded by the use-by date. V. Failed to ensure staff practice safe thawing, cooling procedures and food temperature monitoring (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. Facility policy and procedure The Food preparation policy and procedure revised on September 2017 was provided by the NHA on 2/8/22 at 4:02 p.m. It revealed, in pertinent part, Temperature for time/temperature control for safety (TCS) foods will be recorded at time of service, and monitored periodically during meal service periods . Prepared hot food items that are not intended for immediate service will be cooled using the following guidelines: -Place in shallow pans or cut/slice to promote rapid cooling. -TCS foods will be cooled from 135 F to 70 F within two hours. -TCS foods will be cooled from 70 F to 41 F within four hours -Total cooling time cannot exceed 6 hours. The clock starts at 135 F. B. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, retrieved on 2/14/22, revealed in pertinent part, TCS foods shall be thawed: under refrigeration that maintains the food temperature at five degrees Celsius (C) 41 degrees Fahrenheit (F) or less; or completely submerged under running water: At a water temperature of 21 C (70 F) or below; with sufficient water velocity to agitate and float off loose particles in an overflow Cooked TCS foods shall be cooled: within two hours from 57 C (135 F) to 21 C (70 F); and within a total of six hours from 57 C (135 F) to 5 C (41 F) or less C. Observations On 2/3/22 at 10:47 a.m., there was a container of cooked rice dated 2/1 and a container of turkey with gravy dated 1/31. There was no cooling log in the kitchen showing both products were monitored for safe cooling after it was made. During meal preparation observation on 2/8/22 at 10:20 a.m., there was a plastic bin with a bag of frozen fish in the food preparation sink. Half of the bag was submerged in cold water, but the top half portion of the bag was above water with a small amount of running water. During meal preparation and trayline observation on 2/8/22, Cook #1 took food temperatures when she pulled them out of the oven at 11:32 a.m., but did not take food temperatures again prior to the start of lunch service which was at 12:05 p.m. When the lunch trayline ended at 12:54 p.m., Cook #1 left the line immediately to clean up and did not take end of service food temperatures to ensure steam stable was holding foods at the correct temperatures. (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. Staff interviews The dietary account manager (DAM) was interviewed on 2/3/22 at 2:18 p.m regarding the cooling log. She said she had been working for about three months, and was new to the manager's role for about two weeks now. She had never seen a cooling log in place before and did not know she needed to monitor hot foods when they were cooled down. The GM was interviewed on 2/8/22 at 4:33 p.m. She said all hot foods that required cooling should be monitored for safe cool down temperatures. She said staff probably did not know they needed to record the temperatures on the log. Cook #1 was interviewed on 2/8/22 at 10:38 a.m. She said she defrosted fish in the walk-in refrigerator yesterday but it was still frozen. She placed frozen fish under the running water for quick thawing. At 11:10 a.m., Cook #1 said some fish were still partially frozen because half of the bag was on top of the water, they could not be submerged under water completely because they were in a bag. The GM said frozen fish should be completely submerged if thawed under water. Cook #1 was interviewed on 2/8/22 at 12:05 p.m. when the lunch trayline started. She said she had never taken food temperatures before trayline started. She always took temperature when she pulled foods out of the oven because I needed to know it was cooked to the right temperature. The GM was interviewed on 2/8/22 at 12:54 p.m. when the lunch trayline ended. She said staff did not need to do end of trayline temperature monitoring if the trayline lasted less than two hours.

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	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 43525 Based on observations, record review and staff interviews, the facility failed to ensure garbage and refuse was properly disposed of and the dumpster lid was closed to prevent harborage to pests and insects. Specifically, the facility failed to ensure the dumpster lids were closed, not overfilled, and the surrounding environment was maintained clean. Findings include: A. Facility policy and procedure The Outside Cleaning policy and procedure, revised November 2007, was provided by the nursing home administrator (NHA) on 2/10/22 at 9:00 a.m. It read, in pertinent part, The environmental services director assigns housekeeping employees to police and clean the outside area. Areas include all entrances, exits, sidewalks, driveways, parking lot, dumpster, loading dock, patios, and courtyards. B. 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_6CCR10102_RFFC_EffJan2019.pdf, retrieved on 2/15/22, read in pertinent part; -Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers. -Cardboard or other packaging material that does not contain food residues and that is awaiting regularly scheduled delivery to a recycling or disposal site may be stored outside without being in a covered receptacle if it is stored so that it does not create a rodent harborage problem. -Storage areas, enclosures, and receptacles for refuse, recyclables, and returnables shall be maintained in good repair. -Refuse, recyclables, and returnables shall be removed from the premises at a frequency that will minimize the development of objectionable odors and other conditions that attract or harbor insects and rodents. C. Observations (continued on next page)

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	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/7/22 at 8:45 a.m., two dumpsters in the parking lot were overflowing with trash without lids covering the dumpsters. There were many large bags of trash on the floor, in between and around the dumpsters. On 2/8/22 at 10:55 a.m., both dumpsters were overfilled and not covered. There was trash at the back of the dumpster and a few bags underneath the dumpster. On 2/9/22 at 5:15 p.m., both dumpsters were not covered. One dumpster had both sides of lids flipped to the back, and another dumpster only had one lid covered. There were a few bags of trash on the floor around the dumpsters. D. Staff interview The dietary account manager (DAM) and general manager (GM) were interviewed on 2/9/22 at 11:10 a.m. The DAM said one of the dumpster lids was broken so it could not be covered. She said she had seen trash left on the floor in the dumpster area because of the overflowing dumpster. The GM said she had educated the kitchen staff to keep the lids closed when taking trash out. She said the dumpsters were overfilled a lot of the time. She said trash and debris not covered and left on the floor could attract rodents. The maintenance supervisor (MS) was interviewed on 2/9/22 at 11:27 a.m. He said he just found out one of the dumpster lids broke that day. He said he tried to contact the waste management company for lid replacement today. He said it was his responsibility to ensure the dumpster area was maintained, clean and trash was not overfilled. He and the maintenance staff cleaned the dumpster area every other day. He said trash was collected twice per week and on occasion, three times per week. He said he provided verbal in-services to all staff regarding keeping the lids closed and not overfilling the dumpster.

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	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, record review, and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease in two out of eight units. Specifically, the facility failed to: -Ensure hand hygiene was offered and encouraged to residents at meal time; -Ensure housekeeping staff practiced hand hygiene in between glove changes and disinfect resident rooms in accordance with accepted infection control practices; and, -Ensure staff performed hand hygiene when taking vitals signs. Findings include: I. Failure to offer and encourage resident hand hygiene A. Professional reference According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (Retrieved 2/15/22), Health care professional (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE (personal protective equipment), including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHR (alcohol based hand rub) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. B. Facility policy and procedure The Hand Hygiene policy, reviewed on 11/15/21, was provided by the nursing home administrator (NHA) on 2/10/22 at 9:00 a.m It revealed in pertinent part, Perform hand hygiene before patient care; before an aseptic procedure; after any contact with blood or other body fluids, even if gloves are worn; after patient care; and after contact with the patient's environment. To decontaminate hands with alcohol based rub: Apply product to the palm of one hand and rub hands together, covering all surfaces of the hands and fingers until the hands are dry. C. Observations (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 2/3/22 beginning at 11:43 a.m and ending at 12:03 p.m. Certified nurse aide (CNA) #6 delivered meal trays to room [ROOM NUMBER], 502, 509, and 512 without offering hand hygiene to the residents. During a continuous observation on 2/7/22 beginning at 12:26 p.m. and ending at 12:56 p.m. an unidentified CNA delivered meals trays to room [ROOM NUMBER], 504, 507, 508, 511, 512, 514, and 515 without without offering hand hygiene to the residents. D. Staff interviews The director of nursing (DON) and NHA were interviewed on 2/9/22 at 12:30 p.m. The DON said the proper steps to handwashing were: turn on the faucet, wet hands, apply soap, rub hands together including fingers, nails, back of hands, and wrists for at least 30 seconds, rinse under faucet, dry with paper towel, and turn off faucet with clean paper towel. The DON said when performing hand hygiene with hand sanitizer the process should take about 30 seconds, until the sanitizer was dry. She said if the individual only rubbed their hands together for a few seconds they have not applied enough sanitizer or they have not fully let the sanitizer dry. She said hand sanitizer should be dry before putting on gloves. The DON said the nursing staff are responsible for offering hand hygiene to the residents before and after meals. II. Failure to clean resident rooms appropriately A. Facility policy and procedure The Housekeeping in-service provided by the NHA on 2/10/21 at 10:38 a.m. revealed, in pertinent part, The seven-steps daily washroom cleaning: check supplies, empty trash, dust mop floor, clean and sanitize sink and tub, clean and sanitize commode, spot clean walls, damp mop floor. The five-step patient room cleaning procedure: empty trash, horizontal surfaces, clean walls, dust mop, damp mop. B. Manufacturer's recommendations The Germ-x (hand sanitizer) instructions were provided by the NHA on 2/9/22 at 12:30 p.m. It revealed, in pertinent part, Kills germs in as little as five seconds. Wet hands thoroughly with the product and allow it to dry without wiping. The Peroxide Multi Surface Cleaner and Disinfectant instructions were provided by the NHA on 2/10/22 at 10:38 a.m. It revealed, in pertinent part, The EPA (environmental protection agency) approved contact times when mixed at six ounces per one gallon area as follows: Covid-19: 30 seconds and all other pathogens: three minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Observations During a continuous interview on 2/8/22 starting at 10:11 a.m. and ended at 11:22 a.m. the following was observed: Housekeeper (HSKP) #1 was observed cleaning resident room [ROOM NUMBER]. He grabbed five rags out of a bucket filled with a cleaning solution. He said the cleaning solution was a peroxide multi surface cleaner. He entered the resident's room and placed the rag on the bedside table, night stand, and dresser on both the A side and B side of the room. He gathered three clean mop heads, from the same bucket with the peroxide solution, and placed them on the A side of the room, on the floor. He then left the room. He doffed his gloves, threw them away, and donned a new pair of gloves. He did not perform hand hygiene in between changing his gloves. He re-entered the resident's room with a duster and a bottle of multi surface cleaner. He sprayed the multi surface cleaner on the walls of the bathroom, the toilet, grab bars, and the sink. He finished spraying at 10:26 a.m. He returned to his cart, took out the cart keys from his pocket and locked the multi surface cleaner in the housekeeping cart. He grabbed more clean towels with his contaminated gloves from the bucket and placed them in the bathroom sink. Returning to the housekeeping cart, he doffed his gloves, threw them away and donned new gloves. He did not perform hand hygiene after doffing and prior to donning new gloves. He unlocked the housekeeping cart and grabbed the multi surface cleaner. He sprayed the bedside table on the A and B side of the room. He entered the bathroom again and began wiping surfaces down at 10:28 a.m. only two minutes after the last spray of the peroxide multi-surface cleaner. The peroxide multi-surface cleaner required a three minute time for disinfection (see above disinfectant instructions). He wiped the towel rack and grab bar. Without getting a new towel he then wiped the outside of the toilet (including the front and base of the toilet), and finished with the sink and wall behind the sink. He placed the used rag in a pile by the bathroom door. He grabbed another rag, opened the lid of the toilet, and used the rag to clean the inside of the toilet bowl. He then took the rag, dripping on the floor, and put it in the pile with the other rags on the floor by the bathroom door. He picked up the pile of dirty rags and placed them near the door frame of the bedroom, by the hallway. He doffed his gloves and then donned new gloves. He did not perform hand hygiene prior to donning new gloves. He took a clean mop head from the bedroom floor and mopped the bathroom floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He then began sweeping the bedroom floor, then cleaned the B side furniture with a new rag and swept the B side of the room. Without changing his gloves, HSKP #1 began wiping down the bedside table and nightstand on the A side of the room with a rag. He swept and mopped under the A side bed. He wiped off the fall mat that had dried food particles on it. He then returned the fall mat and the furniture to the original position. With his gloved hands, HSKP #1 touched the inside of the trash bag, inside the trash can and emptied the trash from the B side of the room. He placed the bag by the door and put the trash can back on the B side. With the same gloved hands, he moved the fall mat on the A side of the room and picked up the trash bag. He did not change his gloves after touching the inside of the trash can and moving from the B side of the room to the A side. He went to the housekeeping cart and doffed his gloves. He used alcohol based hand rub (ABHR) on his hands and rubbed for five seconds, he did not allow the ABHR to dry in order to provide proper disinfection. His hands were visibly wet as he began to don new gloves. The gloves clung to the wetness of his hands and he had a difficult time donning the gloves. HSKP #1 swept up the pile of debris he made from cleaning the room and used his gloved hands to touch the bottom of the dust pan to dump debris into the trash can. He then grabbed the mop and moped the B side of the room. He removed the mop head, doffed his gloves, and donned new gloves. He did not perform hand hygiene prior to donning new gloves. During a continuous observation on 2/8/22 beginning at 2:53 p.m. and ending at 3:55 p.m. the following was observed: The housekeeping account manager (HAM) said he was going to do a daily clean on two rooms, each room had only one resident in occupancy. He used ABHR for three seconds and with visibly wet and shiny hands, donned gloves. He entered room [ROOM NUMBER]. He picked up the trash from around the room and emptied the trash cans. He doffed his gloves, used hand sanitizer for three seconds, and donned gloves with visibly wet hands. He grabbed a towel out of a bucket that was filled with peroxide cleaner. He wiped off the nightstand. He placed the dirty rag in a bag used for dirty rags, doffed his gloves, used hand sanitizer for four seconds, and donned new gloves. He grabbed a new rag and wiped off all sides of the dresser. He put the dirty rag away, doffed his gloves, used ABHR for five seconds, and donned new gloves. He swept the entire room, put the broom away, doffed his gloves, used ABHR on his hands for four seconds, and then donned new gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He grabbed a clean mop head and mopped the room. He removed the dirty mop head and put it away. He doffed his gloves, used ABHR for three seconds, and put new gloves on. His hands were visibly wet prior to donning new gloves. He entered the room with a bottle of the peroxide cleaner and sprayed down the toilet, grab bars, and sink. He said he had to wait three minutes from the last spray to begin wiping. He set a timer on his watch and waited the full three minutes. He wiped down the grab bars, sinks, and toilet with clean towels for each section. He disposed of the dirty towels, doffed his gloves, used ABHR for two seconds, and donned new gloves on his visibly wet hands. He grabbed the mop, a new mop head and mopped the bathroom floor. He disposed of the mop head, put away the mop, doffed his gloves, and entered the bathroom to wash his hands. He exited the room and moved the housekeeping cart to room [ROOM NUMBER]. He donned new gloves and emptied the trash in the resident's room. He doffed his gloves, grabbed the dustpan and broom, donned new gloves, and swept the room. He did not perform hand hygiene in between the glove change. He returned to the housekeeping cart, put away the broom and dust pan, doffed his gloves, used ABHR for three seconds, and donned new gloves. His hands were visibly wet from the ABHR. He spot cleaned the walls. He doffed his gloves, sanitized hands for two seconds (only his palms), and donned new gloves. He then grabbed a new rag and cleaned the bedside table and the nightstand. He disposed of the rag, doffed his gloves, used ABHR for three seconds, and donned new gloves. His hands were visibly wet. He moped the floor, took off gloves, sanitized his hands for five seconds, and put new gloves on. He got a new rag and wiped off the rest of the furniture in the room. Took off gloves, sanitized hands for three seconds, and put new gloves on. He grabbed the peroxide cleaner, entered the bathroom, sprayed the surfaces at 3:51 p.m. and set a timer on his watch for three minutes. He entered the bathroom again and wiped each surface with a clean rag. He doffed his gloves, used ABHR for six seconds and then donned new gloves with visibly wet hands. D. Staff Interviews The housekeeping account manager (HAM) and the housekeeping district manager (HDM) were interviewed on 2/9/22 at 1:42 p.m. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The HAM said hand hygiene should be performed before and after glove usage. He said gloves should be changed when moving from a clean surface to a dirty surface. The HAM said when performing hand hygiene hands should be rinsed under running water for 20 seconds, soap was then applied and rubbed on hands, hands are rinsed and dried with a paper towel, and use the paper towel to turn off the sink. The HAM said when performing hand hygiene using ABHR, there is not a specific amount of time the sanitizer should be applied. After reading a hand sanitizer label, he confirmed hand sanitizer should be applied and rubbed on the hands for 15-20 seconds. He said the hands should be dry before donning new gloves. The HAM said the housekeepers should treat the A and B side of the room as separate rooms and not go from one side to the other without changing gloves and performing hand hygiene. The HAM said the room should be cleaned first and the bathroom should be cleaned last. The HAM said the yellow cleaner the staff used was a multi-purpose peroxide cleaner that had a disinfectant time of three minutes. He said staff should spray all surfaces with the cleaner so they are visibly wet and wait three minutes after the last spray to begin wiping to ensure the product had time to disinfect. The HAM said the housekeeping staff were responsible for doing the five or seven step cleaning process daily in every resident's room (indicated in the facility policy above). 43525 III. Failed to ensure proper hand hygiene procedures were followed when taking vital signs A. Observation During a continuous observation on 2/7/22 beginning at 9:10 a.m., and ended at 10:07 a.m., the following was observed: At 9:12 a.m, an unidentified certified nursing assistant (CNA) entered room [ROOM NUMBER] with the vital signs cart. The CNA did not perform hand hygiene prior to entering the room. At 9:46 a.m., the same CNA entered room [ROOM NUMBER] with the vital signs cart. She adjusted the privacy curtain and proceeded to take vital signs for the resident. She did not perform hand hygiene prior to entering the room or after adjusting the privacy curtain. She sanitized the cuff and the machine after taking vital signs. Afterwards, she moved the bedside table for the resident and left the room. She began writing on the clipboard after leaving room [ROOM NUMBER], and then proceeded to room [ROOM NUMBER] with the vital signs cart. She adjusted the resident's privacy curtain and put the blood pressure cuff on the resident's wrist. She did not perform hand hygiene before taking vital signs for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:53 a.m., she took the clipboard to the nursing station to speak with the licensed nurse. She returned to the hallway and entered room [ROOM NUMBER] with the vital signs cart. No hand hygiene was observed after touching the clipboard and prior to entering the room. At 9:57 a.m., she left room [ROOM NUMBER] and closed the door. She entered room [ROOM NUMBER] without performing hand hygiene after touching the door knob. At 9:59 a.m., she left room [ROOM NUMBER] and closed the door. She entered room [ROOM NUMBER] without hand hygiene after touching the door knob. After she finished taking vital signs, she sanitized the vital signs machine and hand cuff, and went directly into room [ROOM NUMBER]. She did not perform hand hygiene prior to entering room [ROOM NUMBER]. At 10:05 a.m., she left room [ROOM NUMBER] and closed the door. She entered room [ROOM NUMBER] without hand hygiene after touching the door knob. At 10:07 a.m., she left 307 and closed the door. She wrote on the clipboard then began to gown up in front of room [ROOM NUMBER]. After she donned gloves and a face shield, she entered room [ROOM NUMBER] with the vital signs cart. She did not perform hand hygiene after touching the clipboard or before donning on gloves. B. Staff interview CNA #7 was interviewed on 2/8/22 at 10:02 a.m. She said facility staff should wash or sanitize their hands before and after leaving a resident's room. The director of nursing (DON) was interviewed on 2/9/22 at 1:23 p.m. She said facility staff should wash or sanitize their hands with ABHR (alcohol based hand rub) in between residents while taking vital signs. She said staff should wash or sanitize hands again if they touch privacy curtains or the bedside table before taking residents' vital signs. She said hand hygiene should be performed prior to donning gloves. 45889