

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2023
NAME OF PROVIDER OR SUPPLIER  Atlas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2611 Jones Ave Pueblo, CO 81004	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42193</p> <p>Based on observations, interviews and record review, the facility failed to ensure residents had the right to a dignified existence out of 42 sample residents.</p> <p>The facility failed to ensure residents experienced a dignified living experience by ensuring residents were treated with respect and dignity. Residents of the facility expressed being yelled and chastised by staff and retaliation by the facility. A resident stated he was tired of feeling like we are nobody, he served his country for freedom and he can't die with dignity; he wanted to be treated like a human being, not a child.</p> <p>Furthermore, the facility failed to treat Resident #83 with respect and dignity.</p> <p>Findings include:</p> <p>I. Residents being treated with respect and dignity (cross-reference F565 resident group response)</p> <p>A. Resident group interview</p> <p>The resident group interview was conducted on 4/20/23 at 11:00 a.m., with 12 alert and oriented residents. The resident in the council meeting said the following:</p> <p>The residents said that dignity and respect had always been a thing around here as residents were always being yelled at and chastised by the staff.</p> <p>One resident said I am tired of the retaliation. When you blow the whistle they retaliate.</p> <p>One of the residents said I am tired of feeling like we are nobody, we are grown adults. The resident then said it makes me wonder why I served my country for freedom and we can't die with dignity. I want to be treated like a human being, not like a child.</p> <p>B. Administrative interview</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The director of nursing (DON) was interviewed on 4/20/23 at 5:00 p.m. The DON said the staff treat the residents with respect and dignity. She said when she received a complaint, she would ensure it was investigated to rule out abuse. She said at times the complaint could be customer service oriented, then the staff would be educated on customer service. She said customer service was taught at orientation and it included respect and dignity. Staff were trained to listen to residents and to ensure the resident was cared for in a dignified manner. She said residents had the right to complain and not to be fearful of retaliation.</p> <p>II. Resident #83</p> <p>A. Resident status</p> <p>Resident # 83, age 81, was admitted to the facility on [DATE]. The April 2023 computerized physicians orders (CPO) indicated that the resident had a diagnosis of chronic obstructive pulmonary disease, insomnia, anxiety disorder, hallucinations, type 2 diabetes and chronic kidney disease.</p> <p>The 3/22/23 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview of mental status score of 15 out of 15. Resident #83 required supervision with eating, support was provided with showers, however the resident refused each time. The resident required the use of a manual wheelchair. The resident was independent with toilet use, dressing, and bed mobility.</p> <p>B. Observation</p> <p>On 4/19/23 at approximately 1:45 p.m. loud arguing between Resident #83 and the receptionist could be heard. Resident #83 was at the front receptionist desk. The resident was telling the receptionist that she had not done something that he had requested. He was talking loud, using foul language and his tone of voice was argumentative. The receptionist was observed to engage the resident with her tone of voice, was also argumentative and she continued to reply back to the resident in a disrespectful manner. She did not talk to the resident in a manner which provided dignity.</p> <p>C. Resident interview</p> <p>Resident # 83 was interviewed on 4/18/23 at approximately 2:00 p.m. The resident said he did not like how the facility staff spoke to him. He said he had to deal with a lot of issues in his life, but the way he was spoken to by facility staff made him upset. He said the staff would not believe him when he asked for assistance and the request was always matched with an argument from the staff. He said he knew he did not communicate his needs in a pleasant manner.</p> <p>The resident was interviewed a second time on 4/19/23 at approximately 2:45 p.m. The resident said that he felt like his right to be treated with dignity was taken from him. He said that he did not think the receptionist should talk to him the way she did.</p> <p>D. Record review</p> <p>The care plan, revised 1/27/23, included that arguing with Resident # 83 made his situation worse which made him feel like he had been scolded in front of the other residents. The social services (SS) advised the staff for the resident to be spoken to in a calm manner which diffuses a situation.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>E. Staff interviews</p> <p>The DON was interviewed on 4/19/23 at 2:08 p.m. She said Resident #83 had been asking the staff all day about the refrigerator in his room to be repaired. She said Resident #83 told her he felt like he had been disrespected by the staff. Resident #83 spoke of an incident in which he spoke to the receptionist about his refrigerator. He said she told him that it was not her job to look at his refrigerator and that he should go talk to the maintenance department about his problem.</p> <p>Certified nurse aide (CNA) #9 was interviewed on 4/19/23 at 4:00 p.m. The CNA confirmed she observed the interaction between the receptionist and Resident #83. She said that although Resident #83 could be difficult, the receptionist should have walked away when he was using foul language rather than using the disrespectful tone.</p> <p>48114</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47024</b></p> <p>Based on observation and interviews, the facility failed to provide a homelike environment for residents on six of six hallways and common areas.</p> <p>Specifically, the facility failed to inform and encourage residents and their families to decorate resident rooms with personal belongings to make it homelike.</p> <p>Findings include:</p> <p>I. Observations</p> <p>Resident rooms</p> <p>Multiple resident rooms throughout the facility on 4/17/23 had no homelike or personalized decorations. The walls were bare or had a facility style picture, nothing personalized.</p> <p>-room [ROOM NUMBER] had no homelike or personalized decorations.</p> <p>-room [ROOM NUMBER] had no homelike or personalized decorations.</p> <p>-room [ROOM NUMBER] had no homelike or personalized decorations.</p> <p>-room [ROOM NUMBER] had no homelike or personalized decorations.</p> <p>-room [ROOM NUMBER]B had no homelike or personalized decorations.</p> <p>-room [ROOM NUMBER]B had no homelike or personalized decorations.</p> <p>-room [ROOM NUMBER] B had no decorations or personalized decoration.</p> <p>-room [ROOM NUMBER]B had no homelike or personalized decorations.</p> <p>-room [ROOM NUMBER]A had no homelike or personalized decorations.</p> <p>-room [ROOM NUMBER] was observed on 4/17/23 at 10:30 a.m. The resident's room was to be plain and bare. There were no pictures on the wall and had no family photos. The resident's room did not look like anyone was living there and was not homelike.</p> <p>-room [ROOM NUMBER] a was observed on 4/19/23 at 9:52 a.m. The resident's room had no personal items (no pictures or decor in the room).</p> <p>II. Resident representative interview</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #11's representative was interviewed on 4/20/23 at 5:03 p.m. She stated that no staff told her her father could have personal belongings in his room.</p> <p>III. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 4/24/23 at 11:00 a.m. The nurse said the residents could have decorations in their rooms, that was their choice. She said the social services department should inform residents and family members they could bring personalized belongings in for the residents' rooms.</p> <p>RN #2 was interviewed on 4/24/23 at 11:00 a.m. She said residents could choose to decorate their rooms and that it was their choice if they wanted stuff in their rooms.</p> <p>The social worker (SW) was interviewed on 4/24/23 at 11:40 a.m. The SW stated that residents were allowed to have their own personal items in their rooms. She said she told the families to not bring in valuables.</p> <p>The SW stated the family brought in a television for Resident #11.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>47024</p> <p>Based on interviews, record review and observations, the facility failed to ensure residents consistently receive food prepared by methods that conserved nutritive value, palatable in taste, texture, appearance and temperature.</p> <p>Specifically, the facility failed to ensure:</p> <ul style="list-style-type: none"> <li>-Resident food was palatable in taste, texture, appearance and temperature;</li> <li>-Meals were served at a palatable temperature; and,</li> <li>-Condiments were provided with meals.</li> </ul> <p>Findings include:</p> <p>I. Resident interviews</p> <p>Resident #45 was interviewed on 4/17/23 at 10:06 a.m. The resident said the food was not good. She said she had complained that when the facility did not have french fries or tater tots, they gave the residents a blob of mashed potatoes. She said she had taken pictures of the pizza that was not appetizing and showed the dietary manager (DM) so he could see what it looked like. She said she had asked for salad for lunch and dinner because the vegetables were overcooked. She said the facility did not have any dressing and they informed her that they did not have the ability to make any. She said the facility overcooked the chicken so it was too dry.</p> <p>Resident #67 was interviewed on 4/17/23 at 10:07 a.m. The resident said he was not a picky eater but when he took the lid off the previous day's breakfast, it smelled like burned hair. He said lunch was ham, it was brown/purple and shriveled up.</p> <p>Resident #31 was interviewed on 4/17/23 at 10:10 a.m. The resident said sometimes the meals were not that great.</p> <p>Resident #4 was interviewed on 4/17/23 at 10:18 a.m. The resident said she had soupy oatmeal and she liked it better when it was thick.</p> <p>Resident #20 was interviewed on 4/17/23 at 10:22 a.m. The resident said the eggs were cold and hard.</p> <p>Resident #81 was interviewed on 4/17/23 at 10:26 a.m. The resident said breakfast had been an egg sandwich and it was cold.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #29 was interviewed on 4/17/23 at 10:49 a.m. The resident said she did not like breakfast. She only ate the egg and the oatmeal was watery and it did not look like regular oatmeal. She said over the last several days breakfast had been no good, it was an egg between two slices of bread that had not been toasted with cheese. She said she could not believe what they served the residents to eat.</p> <p>Resident #8 was interviewed on 4/17/23 4:58 p.m. The resident said most of the time the food was cold, especially since she could not go to the dining room.</p> <p>Resident #83 was interviewed on 4/18/23 at 12:00 p.m. He said the food at the facility was not edible therefore he purchased his own food to keep in his room. He said the staff tried to convince him to eat the facility food but he would not eat it. He said the food at the facility had no flavor.</p> <p>Resident #53 was interviewed on 4/19/23 at 1:00 p.m. The resident said the meatloaf was terrible.</p> <p>II. Resident council interview</p> <p>Resident council was interviewed on 4/20/23 at 11:00 a.m. 12 residents attended and participated in a resident council meeting. The majority of the residents stated the food was terrible, awful and had no flavor.</p> <p>One resident said sometimes the hamburgers were under cooked.</p> <p>Another resident said the food was not prepared properly and was served cold.</p> <p>One resident said the fish had been served raw a few times.</p> <p>Residents reported the facility had run out of food and this had happened numerous times.</p> <p>One resident said he had voiced his concern about the food and nothing happened to resolve the problem.</p> <p>One resident said she made her own meals at least twice a week.</p> <p>One resident said he had food enhancers such as crackers, beef jerky, peanut butter, cheese wiz, salsa and chips and salami kept in his room. He said he had seasonings to give his food some flavor.</p> <p>III. Observation</p> <p>The kitchen was continuously observed on 4/19/23 at 7:30 a.m. until 8:30 a.m. for the breakfast meal.</p> <p>Food temperatures at the serving table were:</p> <p>-Pureed eggs 102.5 degrees F; and,</p> <p>-Pureed cinnamon rolls 95.1 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Meals were not being served at 7:55 a.m. The first delivery cart went to the floor for delivery of breakfast at 8:16 a.m. and serving ended at 8:30 a.m. Only trays that had requested brown sugar had sugar, none of the trays had salt or pepper or any other kind of condiment.</p> <p>The room trays were served on warmed plates, with an insulated cover. However, the plates did not have a hot pellet to keep the plate warm.</p> <p>A test tray of pureed breakfast items was tested at 8:32 a.m. by four surveyors. There were no condiments, including sugar, salt or pepper, available.</p> <p>The temperatures of the meal were:</p> <ul style="list-style-type: none"> <li>-The eggs were 91 degrees F and described as bland, gritty and not flavorful;</li> <li>-The cinnamon rolls were 82.9 degrees F and described as gummy, gluey in texture and had small chunks of dough in it;</li> <li>-The oatmeal was 120 degrees F and was described as watery, bland, not sweet and was liquidy; and,</li> <li>-The milk was 42 degrees F.</li> </ul> <p>IV. Record review</p> <p>Dining committee meeting minutes dated 3/28/23 at 2:00 p.m. documented the residents complained about the menu and food being delivered cold.</p> <p>The resident council minutes from 3/28/23 read in pertinent parts (name of resident) said the kitchen has been running out of foods. Residents are complaining about having fish and chicken all the time and would like different options.</p> <p>V. Staff interviews</p> <p>The dietary manager (DM) and area dietary manager (ADM) were interviewed on 4/20/23 at 2:32 p.m. The DM said he was aware there had been food complaints. He said that the complaints that he had heard from residents included the food required more seasoning. He said the residents did receive salt with their meals, but did not want to add more salt to the food, as some residents could not have salt. He said he heard complaints on repetitive food items and requesting different types of deserts.</p> <p>The DM said the plate warmers were going out and needed to be replaced.</p> <p>The ADM said the facility has not had the heating pellets for over a year. She said that the facility was hoping to get some of the heating pellets for the room trays.</p> <p>The DM said he was required to complete one test tray a month. He said due to the resident complaints, he recently started a food committee. He said the menu was about to change.</p> <p>42193</p> <p>(continued on next page)</p>		



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