STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31524 Based on observation, interview, record review, and review of facility policies, the facility failed to ensure one (Resident #40) of three residents reviewed for nutrition maintained his/her body weight and did not sustain severe weight loss. Specifically, on 07/05/2022 the resident weighed 180.4 pounds and on 07/30/2022, Resident #40 weighed 159 pounds, a 21.4 pound or 11.86 percent (%) weight loss in 25 days. The failed to identify and address Resident #40's severe weight loss. Findings included: A review of the facility's Tracking Weight Changes policy/procedure, dated August 2019, revealed A copy of weight records will be forwarded to the appropriate professional each month. The RD or designee will review monthly weights and calculate significant change over one, three, and six months. The RD or designee will review all significant weight losses, and assess for insidious weight loss as well. The RD or designee will make referrals and take action as necessary (including follow up documentation). A review of Resident #40's Admission Record revealed Resident #40 had diagnoses that included alcoholic cirrhosis of the liver, left femur fracture (06/15/2022), alcohol-induced persisting dementia, muscle wasting and atrophy, and dementia with behavioral disturbance. A review of Resident #40's admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview of Mental Status (BIMS) could not be conducted to assess the resident's cognition. A staff assessment of the resident's cognition indicated the resident had severely impaired cognitive skills for daily decision making. Further review revealed Resident #40 required supervision of one staff for eating and had not sustained weight loss. According to the MDS, Resident #40 weighed 188 pounds. A review of Resident #40's care plan revised on 06/16/2022 revealed the resident had potential for nutritional risk related to a traumatic brain injury (TBI), alcohol-induced persisting dementia, liver cirrhosis, congestive heart failure, depression, and hypothyroidism. The care plan indicated weight fluctuations were possible for Resident #40 due to edema, congestive heart failure with diuretic use, sporadic intake, and refusing weights. Interventions included monitoring and reporting to the physician as needed for signs and symptoms of decreased appetite or unexpected/significant weight loss. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #40's August 2022 physician Order Summary Report revealed an order was initiated on 03/01/2020 for a regular diet and an order was started on 01/07/2022 for snacks three times a day. A review of nutrition Progress Notes dated 06/16/2022 at 1:51 PM revealed Resident #40 was readmitted after a hospital stay from 06/13/2022 to 06/15/2022. The diet order for a regular diet with thin liquids continued. The note indicated the resident had sporadic intakes; however, was requesting snacks. The note revealed the RD would follow up as needed and continue to monitor intake. A review of Resident #40's nutrition Progress Notes dated 06/20/2022, revealed the resident was consuming zero to 100% of meals, with 100% acceptance of one meal per day and sporadic intake with other meals. The note indicated that Resident #40 was previously accepting 100% of snacks three times per day but had declined several snacks since readmission. According to the note, the RD would start Boost (a supplement) twice daily to increase the resident's intake. Further, the note indicated the RD would continue to monitor the resident's monthly weights and meal/snack intake. Continued review of Resident #40's August 2022 physician Order Summary Report revealed an order for Boost twice daily for poor intake was started on 06/20/2022. A review of Resident #40's readmission Nutrition Evaluation, dated 06/23/2022, revealed Resident #40 required help setting up the meal tray and now required the assistance of one person for meals. Further review revealed Resident #40 consumed 50% to 100% of their meals prior to hospitalization for a left femur fracture in June 2022 but Resident #40 consumed 0 - 25% of their meals since readmission. The resident received Boost twice daily and snacks three times per day. According to the note, per the resident's Medication Administration Record (MAR), the resident was consuming 100% of supplements. Further review revealed Resident #40's weight on 06/07/2022 was 188 pounds and was stable on diuretic therapy with expected weight fluctuations. Facility staff held a care conference on 06/20/2022 and Resident #40's family member was concerned with Resident #40's reduced meal intake. According to the note, the resident's last weight before hospitalization was stable. The RD then wrote, unknown if resident is currently meeting [his/her] estimated energy needs with intake. The RD recommended continuing the current diet order, obtaining a current weight, and monitoring food intakes. A review of Resident #40's Weight Summary revealed on 06/07/2022, prior to transferring to the hospital, the resident weighed 188.0 pounds. Further review revealed on 07/05/2022 the resident weighed 180.4 pounds (an eight pound or 4.4% weight loss). On 07/30/2022 and 08/03/2022, Resident #40 weighed 159 pounds, an 11.86% weight loss in less than 30 days, and 15.43% in less than 60 days. Continued review of Resident #40's Progress Notes, Physician Order Summary, and care plan revealed no documented evidence the facility identified and addressed the resident's weight loss on 07/05/2022, nor the severe weight loss on 07/30/2022. A review of Resident #40's Amount Eaten report, dated 08/01/2022 to 08/30/2022, revealed the resident's meal intakes varied from zero to 100% and the resident refused nine meals during the month of August 2022. An observation of Resident #40 on 08/30/2022 at 11:45 AM revealed the resident was in his/her room. Staff set up the meal tray and the resident was eating. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/30/2022 at 1:22 PM, Certified Nurse Aide (CNA) #1 stated Resident #40 had variable intake at meals, and she offered snacks if Resident #40 refused a meal. According to CNA #1, the resident could verbalize when he/she was hungry. CNA #1 further stated Resident #40 looked as though he/she had lost weight since the resident's femur fracture in June 2022. However, CNA #1 did not notify anyone that Resident #40's clothes looked looser than normal because Registered Nurse (RN) #1 already knew Resident #40 had lost weight. During an interview on 08/30/2022 at 1:35 PM, Registered Nurse (RN) #1 stated she was not aware that Resident #40 had a weight loss. According to RN #1, the RD notified her of any residents with severe weight loss or any new orders; however, the RN had not been notified of weight loss for Resident #40. According to RN #1, Resident #40 ate a regular diet and had good food intake, and the resident's weight did not appear any different. During an interview on 08/30/2022 at 2:00 PM, CNA #2 stated she obtained Resident #40's weight on 08/03/2022 and when she input the weight into the electronic medical record (EMR), she compared the current weight to the previous weight. CNA #2 stated she normally notified RD #2 verbally if there was more than a five-pound difference from the previous weight. CNA #2 further stated when a resident had weight loss, the RD followed up and communicated with nursing regarding any significant weight changes. However, CNA #2 did not remember if she notified RD #2 of Resident #40's weight loss from July 2022 to August 2022. CNA #2 stated if she had notified the RD, it would not have been documented. During an interview on 08/30/2022 at 2:12 PM, RD #2 stated she had been covering the facility since May 2022 and followed residents from week to week. She stated she did not complete a progress note if there were no changes between quarterly nutrition assessments. She stated if a resident had a wound, significant weight loss, or if she was notified a resident was not eating/refusing meals, she would follow up with the resident to see if any supplements were in place or if they just did not like what was being served. If the resident had a higher need, the RD stated she typically would follow the resident weekly to see if there were any changes. RD #2 stated the last time she assessed Resident #40 was on 06/23/2022, when she completed a readmission nutrition assessment. RD #2 stated she reviewed each resident's monthly weight but had overlooked Resident #40's severe weight loss in August 2022. According to RD #2, she was supposed to notify the resident's family and physician and implement new nutrition interventions as needed for weight loss. RD #2 stated it was important to identify significant weight changes and/or the need for nutritional interventions, and to implement them timely to prevent further weight loss, malnourishment, or skin breakdown. During an interview on 08/30/2022 at 2:58 PM, the resident's physician (Physician #1) stated the previous week, the facility notified him that Resident #40 had decreased intake; however, the physician stated he was not aware the resident had weight loss. The physician further stated Resident #40 had psychiatric diagnoses and a femur fracture and a severe weight loss in that short time was concerning. Physician #1 further stated the decreased intake could have been a side effect of the recovery process following the femur fracture or from pain medications. The physician stated the resident had edema after the hospitalization , and some weight loss could have been expected but the resident had sustained a lot of weight loss quickly. According to the physician, the facility should notify him of any significant changes so he could follow up and implement appropriate interventions to provide proper care. He further stated he expected to be notified because if a resident could not communicate feelings or symptoms, it was a sign of a much bigger problem than not liking the food or needing assistance. Physician #1 stated if the facility had notified him, he would have implemented different interventions such as supplements and an RD consult for an enhanced nutrition plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/31/2022 at 1:55 PM, the Director of Nursing (DON) revealed the RD was responsible for reviewing residents' weights, identifying weight loss, and notifying the resident's physician of weight loss. The DON stated significant weight loss should be identified by the RD, then discussed during the facility's weekly standard of care meetings, where the cause of weight loss was assessed. According to the DON, the facility discussed Resident #40's weight loss and the RD determined the loss was due to diuretic use. However, there was no documented evidence the facility assessed/addressed the resident's severe weight loss. The DON further stated they should have discussed Resident #40 more at their weekly meetings to assess for other possible contributing factors such as medication side effects, the femur fracture, or increased nutritional needs. The DON stated it was important to identify a significant weight loss early so interventions could be implemented to prevent further weight loss or decline. During an interview on 08/31/2022 at 3:10 PM, the Administrator stated interventions should have been discussed to prevent further weight loss when Resident #40 had a significant weight loss in August 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 31524 Based on observation, interview, document review, and review of facility policy/procedure, the facility failed to maintain proper kitchen sanitation for the dish machine. Specifically, the dish machine sanitizer was required to be 50-100 parts per million (ppm) to ensure dishes were sanitized. Observations on 08/29/2022 revealed there was no sanitizer in the dish machine. This had the potential to affect 84 of 85 residents. Findings included: A review of the facility's Cleaning Dishes/Dish Machine policy/procedure, dated January 2021, revealed All flatware, serving dishes, and cookware will be washed, rinsed, and sanitized after each use. Dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitation. Further review of the policy/procedure revealed, Prior to use, run the machine until verification of proper temperatures and machine function is made. Verify that soap and rinse dispensers are filled and have enough cleaning product for the shift. You many need to run the machine multiple times to reach a temperature of 120 degrees Fahrenheit (F). Temperatures and PPM [of sanitizer] may be recorded on the dish machine temperature log. A review of the Low Temperature Dish Machine and Sanitizer Log for August 2022, revealed, Instructions: Record the wash temp [temperature in degrees Fahrenheit (F)], rinse temp, and the sanitizer level (ppm) of the dish machine before washing dishes for each meal. If the levels are out of acceptable range, do not wash dishes and notify the supervisor. According to the log, the manufacturer's guidelines were, Sanitizer Level (ppm): 50-100 ppm (check sanitizer container to confirm). Further review of the log revealed the log was not completed (blank) for the dish machine temperature and PPM before washing dishes for the breakfast meal on 08/29/2022. During an observation on 08/29/2022 at 9:45 AM, it was revealed that three to four loads of dirty dishes went through the dishwasher wash cycle at 125 degrees F. Dishwasher #1 staff member used test strips to test the PPM of the sanitizer and the test strip did not change color, indicating no sanitizer was present. An interview with Dishwasher #1 on 08/29/2022 at 9:45 AM, revealed she tested the sanitizer before washing dishes and it was supposed to be 10 PPM. During an observation on 08/29/2022 at 9:46 AM, Registered Dietician (RD) #1 tested the sanitizer with a new strip and the strip did not change color. Again, indicating no sanitizer was present. According to an interview with RD #1 on 08/29/2022 at 9:47 AM, dish machine sanitizer concentration should be 50 to 100 PPM and the test strips were not reading there was sanitizer in the machine. RD #1 then instructed the Dietary Manager (DM) and Dishwasher #1 to stop using the dish machine and to use disposable products for the lunch meal. A follow-up interview on 08/29/2022 at 10:05 AM with RD #1 confirmed the dish machine temperature and sanitizer PPM was not documented that morning. She stated she was not sure if Dishwasher #1 staff member tested the temperature or PPM before washing dishes because it was not working properly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/30/2022 at 2:08 PM, the Dietary Manager (DM) stated she expected staff to test the dish machine's temperature and sanitizer PPM before washing any dishes to ensure the machine was working properly. The DM stated staff were also required to document the results on the Low Temperature Dish Machine and Sanitizer Log to keep a record to monitor for proper sanitation. The DM further stated it was important to test the temperature and sanitizer PPM because the dish machine was a low temperature machine, and they could not rely on hot water alone to properly sanitize the dishes. During an interview on 08/31/2022 at 1:55 PM, the Director of Nursing (DON) stated he expected dishes to be properly sanitized between uses. It was important to ensure adequate sanitation because it was an important part of infection control to prevent the spread of viruses and disease. During an interview on 08/31/2022 at 3:10 PM, the Administrator stated he also expected dishes to be properly sanitized following each use. The Administrator stated if the dish machine or sanitizer was not working properly, the kitchen staff should use disposable products until it was functioning properly to prevent cross contamination and the spread of disease.