STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065139	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society -- Loveland Village	2101 S Garfield Ave Loveland, CO 80537

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on record review and interviews, the facility failed to ensure one (#58) of six residents reviewed for accidents out of 39 sample residents remained free from accidents. Resident #58, who was known to be a fall risk and had care planned fall interventions in place, sustained a fall on 4/20/24 which resulted in a fracture of her left femur (upper leg). During the facility's investigation of the fall, it was discovered the floor alarm, which was care planned as an effective fall intervention for the resident, had been in the off position at the time of the resident's fall and did not sound, therefore staff had not been alerted to the resident's movements in her room. Staff was aware that in order to reset the alarm after it had been triggered, it was necessary to reset the alarm by switching it to the off position and returning it to the on position. However, staff failed to ensure the alarm was in the on position at the time of the resident's fall. Due to the facility's failure to ensure staff reset the alarm appropriately after it had been triggered, Resident #58 sustained a fall on 4/20/24 which resulted in a fracture of her left femur. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 5/1/24 to 5/7/24, resulting in the deficiency being cited as past noncompliance with a correction date of 5/4/24. I. Incident on 4/20/24 The facility failed to ensure staff reset Resident #58's floor alarm, which had been implemented as an effective fall intervention for the resident, appropriately to the on position after the alarm triggered. Due to the facility's failure, Resident #58 sustained a fall on 4/20/24 which resulted in a fracture of the resident's left femur. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review and interviews during the onsite investigation confirmed the deficient practice had been corrected and the facility was in substantial compliance at the time of the survey from 5/1/24 to 5/7/24. II. Facility plan of correction A. Immediate action to correct the deficient practice for Resident #58 The corrective action plan implemented by the facility in response to Resident #58's fall on 4/20/24 was provided by the director of nursing on 5/6/2024 at 10:00 a.m. On 4/20/24, the facility conducted an investigation of Resident #58's fall. The facility interviewed all staff on duty who were involved in care for the resident on the day of fall and a few days prior to the fall. Inspection of the floor alarm device determined the alarm device was in an off position at the time of the fall and therefore did not alert the staff about the resident's movement in the room. All interviewed staff reported that the alarm was functioning well and they heard the sound of it during their shift. Staff was aware that in order to reset the alarm after it was triggered, it was necessary to switch it to the off position and return it to an on position. It was unclear when the alarm was reset for the last time and why it was in the off position at the time of the fall. The last interaction with the resident was reported around 6:30 p.m., about 30 minutes prior to the fall, when a staff member assisted the resident with care. On 4/20/24 all direct care staff who were involved in Resident #58's care and had access to the alarm device were educated on how to reset it and to make sure it was turned on. The device was to be checked at the beginning of every shift and on an as needed basis. Staff were to ensure it was in the on position after the reset. A log was initiated to ensure every shift checked the alarm. On 4/24/24 the interdisciplinary team (IDT) met to review the fall for the Resident #58. Medications, care routines, non-pharmacological interventions and resident preferences were reviewed. The IDT recommended adding the following interventions and continuing to monitor: Bariatric bed for extended sleep surface, improve lighting in the room, and add an air mattress. B. Identification of other residents The facility completed an audit and identified other residents in the building who were at risk for falls. Thirteen identified residents were reviewed for appropriate fall interventions and care plans were updated to ensure the accuracy of the interventions. The audit review was completed by 5/3/24. C. Systemic changes (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nursing leadership re-educated the nursing staff in regards to reviewing the care plan and Kardex (tool utilized by staff to provide comprehensive care of the residents) as well as the importance of following and implementing interventions outlined in these documents in an effort to reduce the risk of falls for facility residents. The training of all staff was completed on 5/3/24. On 4/21/24 audits were initiated to verify fall prevention interventions outlined in the care plans for residents identified to be at risk of falls were in place accordingly via direct observations when rounding as well as via interviews with staff. D. Monitoring The director of nursing (DON) was responsible for completing the audits weekly for the next four weeks, one a month for the next two months and quarterly for the next three quarters. A monthly Report Out, summarizing the findings of the audits, was to be completed and provided to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Report Out was to be reviewed by the QAPI Committee for compliance and trends and to make additional recommendations as needed for continued improvement. The facility would be in substantial compliance by 5/4/24. Interviews and record review during the investigation revealed corrective actions to identify the resident and other residents who had the potential to be affected by the deficient practice, systematic changes to prevent its recurrence, and monitoring to ensure sustained corrections were in place. III. Facility policy The Fall Prevention And Management- Rehab/Skilled, Therapy & Rehab (rehabilitation) policy, revised on 4/2/24, was provided by the nursing home administrator (NHA) on 5/7/24 at 2:10 p.m. It read in pertinent part, The policy's purpose is to promote resident well-being by developing and implementing a fall prevention and management program, to identify risk factors and implement interventions before a fall occurs, to give prompt treatment after a fall occurs and to provide guidance for documentation. On admission or readmission, review the applicable documents (discharge summary from transferring agency, transfer record, history and physical, lab values, nursing admit/readmit data collection) and any additional admit information documentation for fall risk factors. IV. Resident #58 A. Resident status Resident #58, age 81, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included muscle weakness, dementia with behaviors and history of falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 1/19/24 minimum data set (MDS) assessment revealed, resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 12 out of 15. Resident #58 did not have any physical limitations and she used a manual wheelchair. The resident required the assistance of one person for most activities of daily living (ADL). She had at least two falls since she was admitted with no major injury. B. Record review Resident #58's fall care plan, initiated 8/25/2020 and revised 5/1/24, revealed the resident was at risk for falls and had had actual falls related to diagnosis of dementia, failure to thrive, poor safety awareness, weakness and poor balance. The resident was legally blind. Interventions included reminding the resident and encouraging her to use grab bars to prevent falls, using a padded floor alarm with the alarming device in the nurses station where the alarm alerted staff but did not sound in the resident's room to avoid scaring the resident (initiated 11/22/21), Adding anti-slip strips to the total length of the bedside area and by the sink to prevent slips leading to falls (initiated 6/28/23), adding padding to the sink to prevent injury, adding a bedside commode (without the bucket insert), with handles, over the toilet to help guide the resident to know when she had reached the toilet to sit down safely, adding a grab bar in the room to allow safety when the resident was getting out of bed and returning to bed (initiated 7/12/23) and extending the sleep surface on the opposite side of the bed to allow the resident to move and sleep sideways and help prevent falls (initiated 4/24/24). According to the fall incident report, on 4/20/24 around 7:00 p.m., Resident #58 sustained a fall. Staff found the resident sitting on the floor in no acute distress, between her bed and the sink area, scooting backwards on her bottom towards the sink wall. Resident #58 stated she was just walking toward her door and fell . Resident #58 initially denied pain or injury. The physician was notified on 4/20/24 and x-rays were ordered due to increased discomfort in the resident's left leg. On 4/21/24 the results of the x-ray revealed Resident #58 had sustained a left femur fracture and the resident was transferred to the emergency room for further evaluation. According to the hospital discharge summary, dated 4/23/24, Resident #58 was admitted to the hospital on 4/21/24 after she had a mechanical fall at the long-term care facility. She was diagnosed with a left femur fracture. The resident's family chose not to pursue surgical repair of the femur fracture and the resident returned to the facility with a palliative care consultation on 4/23/24. V. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/6/24 at 1:15 p.m. LPN #1 said Resident #58 was currently bed bound after she had a fall in April 2024. She said the resident had a special floor alarm that alerted the staff at the nurses station about the resident's activity in the room. She said Resident #58 had the alarm for a long time and it was very effective at preventing falls. She said she had not worked on the day when Resident #58's fall occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LPN #1 said she was re-educated about alarm monitoring and its functioning a few weeks ago (April 2024). She said her responsibility was to check the alarm when she started her shift, every time it was reset and as needed to ensure the alarm was on. She said she usually checked it every time she was at the nurses station or at least every 20 minutes. Certified nurse aide (CNA) #1 was interviewed on 5/6/24 at 1:35 p.m. CNA #1 said Resident #58 required extensive assistance of two people with all cares. She said the resident was a risk for falls and her responsibility was to ensure the floor mattress that had an alarm was appropriately positioned, plugged in and turned on. She said the resident currently was not able to ambulate but she was still at risk of sliding off the bed. She said the floor alarm's sounding device was at the nurses station and she was familiar with its sound and knew how to reset it after it was triggered. She said the most recent education about the alarm was a few weeks ago (April 2024). The DON and the NHA were interviewed together on 5/7/24 at 11:00 a.m. The DON said Resident #58 was the only resident in the building who was using the type of alarm she had. He said it proved to be effective in preventing falls for the resident and the resident had been using it for a while. The DON said, on 4/20/24 when Resident #58 had the fall, the alarm was found to be in the off position. He said it was inconclusive at what point the alarm was switched off and the most probable cause was that the last person who reset the alarm did not switch it all the way to the on position. He said since the incident occurred, he had completed the investigation and re-educated staff on checking the alarm prior to the shift and on an as needed basis. The DON provided copies of the audits the facility had implemented on to ensure the alarm was being monitored to make sure it was in the on position. The NHA said she believed the facility had completed a thorough investigation and ensured that all residents at risk for falls had appropriate and effective fall interventions in place. She said the facility had taken appropriate actions following Resident #58's fall and ensured the safety of all residents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not five percent (%) or greater. Specifically, the facility's medication error rate was 7.7% or two errors out of 26 opportunities for error. Findings include: I. Professional references According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 606-607, retrieved on 5/06/24, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. According to the Food and Drug Administration (FDA) Metoprolol Succinate Extended-Release Tablets: 25 milligram (mg), 50 mg, 100 mg, and 200 mg, retrieved on 5/9/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2006/019962s032lbl.pdf, Metoprolol Succinate extended-release tablets are scored and can be divided, however, the whole or half tablet should be swallowed whole and not chewed or crushed. II. Facility policy and procedure The Medication Administration policy, dated 3/29/23, was provided by the director of nursing (DON) on 5/6/24 at 12:00 p.m. It read in pertinent part, Nursing assessment is a function of the registered nurse. When the location uses medication aides, the delegating nurse is accountable for assessing a situation and making the final decision to delegate. Follow the Six Rights: right medication, right dose, right resident, right route, right time, and right documentation. III. Resident #62 A. Resident status (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #62, age greater than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included chronic kidney disease stage II (mild) and hypertension (high blood pressure). B. Record review According to the May 2024 CPO, Resident #62 was scheduled to receive the following medication: Nebivolol HCL (a medication used to treat high blood pressure) 2.5 milligrams (mg) one tablet by mouth one time a day for hypertension, and to hold the medication for a systolic blood pressure less than 100 millimeters of mercury (mmHg) or a heart rate less than 60 beats per minute (bpm), ordered 12/3/23. C. Observation On 5/6/24 at 9:30 a.m. the certified nurse aide with medication aide authority (CNA-Med) administered Nebivolol to Resident #62. The CNA-Med failed to check the resident's blood pressure or heart rate prior to administering the medication to the resident. D. Staff interview The CNA-Med was interviewed on 5/6/24 at 9:45 a.m. The CNA-Med said if vital signs were needed before giving a medication, either a heart icon was present under the medication order, or if you hovered over the order, medication parameters were listed within the further instructions section. The CNA-Med said Resident #62's order did not have a heart icon and when she hovered over the medication order, the blood pressure and heart rate parameters were not listed first under further instructions. The CNA-Med said she would take vital signs sometime that day (5/6/24). 50315 IV. Resident #49 A. Resident status Resident #49, age greater than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included fracture of the left and right femur (thigh bone), hypertension (high blood pressure) and heart failure. B. Record review According to the May 2024 CPO, Resident #49 was scheduled to receive the following medication: Metoprolol Succinate (a medication used to treat high blood pressure) extended release (ER) oral tablet 25 mg, give half a tablet by mouth in the morning related to essential (primary) hypertension. Hold for systolic blood pressure (SBP) under 110 or heart rate under 65, ordered 3/27/24. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Observation On 5/2/24 at 9:44 a.m., registered nurse (RN) #1 was administering medications to residents. She looked at orders for Resident #49. There was an order to check vital signs before administration of medication. She took a vital signs cart into the resident's room and measured the resident's heart rate and blood pressure. They were both within normal limits to administer the medication. She walked back to her medication cart and pulled out each medication scheduled to be administered RN #1 crushed all of the medications, including the metoprolol, and mixed them with applesauce. She walked into the resident's room and administered the medications. -However, according to the manufacturer's recommendations for metoprolol succinate extended release tablets, the medication should be swallowed whole and not chewed or crushed (see professional references above). V. Additional staff interviews The DON and unit manager (UM) #1 were interviewed together on 5/6/24 at 10:49 a.m. UM #1 said when original medication admission orders were entered, they were to be signed-off by two nurses. He said when vital signs or weights were needed prior to giving medications, the heart symbol should have shown up on the medication administration record (MAR) as a visual cue to check the resident's vital signs. UM #1 said since there was no heart icon on Resident #62's MAR for the Nebivolol, it meant whoever entered the medication order into the electronic medical record (EMR) missed that step of the entry process. The DON and UM #1 said physician's orders should always be followed. They said not all medications, even blood pressure medications, required vitals signs be checked prior to administration. -However, the physician's order for Resident #62's Nebivolol had specific systolic blood pressure and heart rate parameters for when the medication should not be administered. UM #1 said it was important to follow the physician's orders in order to maintain a safe regulatory system and monitor if the medication was working correctly. He said he would review residents' physician's orders to ensure the nurses were alerted when vital signs were required prior to medication administration. The DON said he would provide education to nurses to ensure the blood pressure and heart rate were checked prior to administering medications if it was requested in the physician's order. The DON said the facility provided education to staff on 5/2/24 regarding not crushing ER medications. UM #1 said extended release medications should never be crushed. He said this was because the medication was not processed in the body like it was intended if the medication was crushed. He said crushing the medication had the potential to give the medication a stronger effect on the resident causing the resident's blood pressure to get too low.