STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065142	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lemay Avenue Health and Rehabilitation Facility	4824 S Lemay Ave Fort Collins, CO 80525

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to ensure three (#13, #11 and #12) of three residents out of 11 sample residents had their grievances resolved promptly by the facility. Specifically, the facility did not promptly respond to Resident #13, Resident #11 and Resident #12's grievances of long call light times. Findings include: I. Facility policy and procedure The Grievance Procedure policy, revised on 10/31/24, was provided by the nursing home administrator (NHA) on 2/19/25 at 6:10 p.m. The policy revealed the purpose of the policy was to protect resident rights and ensure prompt resolution of grievances. If at any time, a resident or representative had a grievance, it was their responsibility to express it orally or in writing to the nursing home administrator (NHA) or designee. Each resident had the right to voice grievances without discrimination, reprisal, or retribution. The facility had a Grievance Committee, which consisted of the NHA or their designee, a resident selected by the facility's residents and a third person agreed upon by the NHA and the facility's resident representative. The NHA or designee was responsible for overseeing the process to the conclusion, maintaining confidentiality, issuing written decisions and coordinating with regulatory agencies as necessary. A review of the grievance would be completed within three (3) calendar days of receiving the grievance and a written explanation of the findings with proposed remedies would be provided. If dissatisfied with the findings and remedies, the aggrieved party might appeal to the Grievance Committee within ten (10) calendar days of receiving the written explanation. The committee would confer with the person involved, within ten (10) calendar days of the date of the appeal and would provide a written explanation of the findings and the proposed remedies. II. Resident #13 A. Resident status (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13, age greater than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included unsteadiness on feet, history of falling, muscle weakness, lack of coordination, urine retention, atherosclerotic heart disease of native coronary artery without angina pectoris, and abnormalities of gait/mobility. According to the 1/6/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required partial/moderate assistance with the staff, provided less than half of the effort with the staff lifting or holding the resident's trunk/limbs and provided less than half of the effort for toileting. B. Resident interview Resident #13 was interviewed on 2/19/25 at 1:53 p.m. Resident #13 said he had waited up to 40 minutes for staff to answer his call light. He said he had defecated in his pants waiting on staff to answer the call light. He said this made him feel terrible and degraded. He said there had been times when he put his call light on and had to ambulate, using his wheelchair, down to the nurse's station from his room at the end of the hall to go ask them why they were not answering the call lights. He said the staff did not give him a sufficient answer to this question. He said at times, staff came into his room, turned the call light off and did not come back. He said he had to turn the call light on again to get the staff to come back to his room and the staff told him that they forgot about him. Resident #13 said sometimes his catheter bag became full and spilled over into the privacy bag because he was waiting on staff to answer the call light. He said this made him angry as well. C. Resident grievances Resident #13's initial concern report, dated 12/10/24, documented the resident and his daughter reported intermittent long call light times. The resident complained of call light time issues with his catheter. -The report did not contain documentation to indicate if the resident was satisfied with the findings or remedies for long call light times. -The report did not provide information on how the resident would initiate the appeal process to the Grievance Committee. Resident #13's initial concern report, dated 1/22/25, documented the resident complained of long call limes. -The report did not contain documentation to indicate if the resident was satisfied with the findings or remedies for long call light times. -The report did not provide information on how the resident would initiate the appeal process to the Grievance Committee. D. Staff interviews (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA, the social services director (SSD) and the assistant social services director (ASSD) were interviewed together on 2/19/25 at 3:41 p.m. The ASSD said she completed Resident #13's initial concern reports dated 12/10/24 and 1/22/25. The ASSD agreed the forms did not reveal if the resident was satisfied with the findings or remedies for long call light times. The NHA, the SSD and the ASSD agreed a call light should remain on until the resident's needs were addressed. The NHA, the SSD and the ASSD agreed staff should not turn the call light off and not come back. III. Resident #11 A. Resident status Resident #11, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included atrial fibrillation, retention of urine, presence of other cardiac implants and grafts-[NAME] implant, heart failure, abnormalities of gait/mobility, lack of coordination, muscle weakness, unsteadiness on feet, difficulty in walking and type 2 diabetes mellitus with other skin complications-with necrotizing fasciitis. According to the 1/27/25 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required substantial/maximal assistance with the staff, provided more than half of the effort with the staff lifting or holding the resident's trunk/limbs and provided more than half of the effort for toileting. B. Resident interview Resident #11 was interviewed on 2/19/25 at 10:55 a.m. Resident #11 said she had to wait up to one hour and 40 minutes at times for staff to answer her call light. She said it made her feel that she did not count as a person when she had to wait on the staff so long. She said staff would come into the room, turn the call light off and did not come back to help her. She said she urinated on herself at times while she waited on staff to answer the call light. Resident #11 said she was frustrated that the staff took a long time to answer the call light because she could not care for herself and had to wait on the staff. C. Resident grievance Resident #11's initial concern report, dated 11/4/24, revealed the resident complained of long call light times. -The report did not contain documentation to indicate if the resident was satisfied with the findings or remedies for long call light times. -The report did not provide information on how the resident would initiate the appeal process to the Grievance Committee. D. Staff interviews (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA, the SSD and the ASSD were interviewed together on 2/19/25 at 3:27 p.m. The ASSD said she filled out Resident #11's initial concern report dated 11/4/24. The ASSD agreed the form did not reveal if the resident was satisfied with the findings or remedies for long call light times. She said the report did not provide information on how the resident would initiate the appeal process to the Grievance Committee. The NHA, the SSD and the ASSD agreed an acceptable call response time average was ten minutes or less. VI. Resident #12 A. Resident status Resident #12, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included multiple sclerosis, retention of urine, muscle weakness, lack of coordination, unsteadiness of gait and the need for assistance with personal care. According to the 12/18/24 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required partial/moderate assistance with the staff, provided less than half of the effort with the staff lifting or holding the resident's trunk/limbs and provided less than half of the effort for toileting. B. Resident interview Resident #12 was interviewed on 2/19/25 at 12:50 p.m. Resident #12 said he had waited up to one and one half hours for staff to answer the call light. He said during this long wait (one and one half hours), he needed to pick something up off the floor and when he reached for the item, he said he fell to the floor, with no injuries. He said he should have waited for the staff, but it took a long time. Resident #12 said it was very common for staff to come into the room, turn the call light off and never come back. C. Resident grievance Resident #12's initial concern report, dated 1/28/25, revealed the resident reported that he pressed the call light at 3:50 p.m. and called his wife, who worked at the facility, at 5:25 p.m. to tell her how long he had been waiting on staff to answer his call light. A certified nurse aide (CNA) came into the room at approximately the same time the resident called his wife. D. Staff interviews The NHA, the SSD and the ASSD were interviewed together on 2/19/25 at 3:49 p.m. The ASSD said she filled out Resident #12's initial concern report dated 1/28/25. The ASSD agreed the form did not reveal if the resident was satisfied with the findings or remedies for long call light times. She said the report did not provide information on how the resident would initiate the appeal process to the Grievance Committee. The NHA said the root cause of Resident #12's fall was his arm got in the way of the wheel chair remote. (continued on next page)

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