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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065188	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Morrison	150 Spring St Morrison, CO 80465

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711 Based on record review and interviews, the facility failed to ensure one (#3) of three residents reviewed out of 15 sampled resident representatives were immediately informed of an accident involving the resident. Specifically, the facility failed to notify Resident #3's representative following the resident's low blood pressures that created a change of condition ultimately resulting in the resident being transferred out to an acute care hospital. Findings include: I. Facility policy and procedure The Notification of Changes policy, revised January 2023, was received from the nursing home administrator (NHA) on 2/26/25 at 9:08 a.m. It read in pertinent part, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification, as a transfer or discharge of the resident from the facility. II. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE] and discharged to the hospital on 2/19/25. According to the December 2024 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease, dementia with moderate behavioral disturbance, hypertension, depression, anxiety, and difficulty in walking. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/13/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for a mental status (BIMS) score of six out of 15. He required minimal assistance with activities of daily living (ADL). B. Record review The 2/19/25 nursing note, documented at 9:53 a.m., revealed Resident #3 sustained a change of condition and was shaking and jerking uncontrollably. Registered nurse (RN) #1 assessed Resident #3 and identified the resident's blood pressure had significantly dropped from the prior set of vital signs that were taken at 7:53 a.m. At 7:53 a.m. the resident's blood pressure was 130/68 milliliters of mercury (mmHg) and at 9:53 a.m. the resident's blood pressure was 80/50 mmHg. RN #1 contacted the nurse practitioner, who was in the facility, for direction on care. After the nurse practitioner provided care, it was decided to transfer Resident #3 to the hospital as treatment was ineffective. -Review of the resident's electronic medical record (EMR) did not reveal documentation indicating the resident's representative was notified of the resident's change of condition or that the resident was transferred to the hospital. The 2/19/25 transfer/discharge form revealed the resident's representative was notified of the resident's change of condition on 2/20/25. -The resident's representative was not notified until the following day after Resident #3 experienced a change of conditioning and was transferred to the hospital. The NHA provided documentation that revealed the resident's representative emailed the NHA on 2/20/25 at 3:40 p.m. after she had received a text message from the local hospital regarding Resident #3's stay in the hospital. The email documented, the resident's representative said she had not been notified by the facility staff that Resident #3 had been transferred to the hospital. III. Staff interviews RN #1 was interviewed on 2/25/25 at 1:02 p.m. RN #1 said RN #2 had told him that he did not attempt to contact Resident #3's representative on 2/20/25 after the resident was transferred to the hospital. RN #1 said that RN #2 told him that after Resident #3 left the facility, he moved on to the next resident task and forgot to complete the notification to Resident #3's representative. RN #1 said he asked RN #2 if he should notify Resident #3's representative and RN #2 said that she had just spoken to Resident #3's representative and it was not needed. RN #1 said RN #2 also told him that the interim director of nursing was going to contact Resident #3's resident representative. RN #1 said the physician and family should always be notified immediately following an incident involving a resident. RN #1 said Resident #3 had dementia and the resident's representative made all medical decisions. He said the resident's representative should be notified with any change in condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 2/25/25 at 4:00 p.m. The NHA said Resident #3's representative was not notified when Resident #3 had a change of condition and was transferred to the hospital on 2/19/25. She said she expected the nursing staff to notify the physician and resident's representative after a change of condition. The NHA was interviewed again on 2/26/25 at 11:08 a.m. The NHA said the process for notifying resident representatives depended on the type of change in condition the resident had experienced. The NHA said if the resident was experiencing an emergent change that required immediate transfer to hospital, then the notification was made when the resident left the facility and was in transit to hospital, but it must occur prior to resident arriving at hospital. The NHA said if the change in condition was not emergent then the resident's representative should be called immediately. The NHA said a clinical meeting occurred every Monday through Friday to review risk management to ensure notifications to responsible parties were completed. The NHA said the supervisor on the weekend mimicked this process. The NHA said when a resident was admitted to the facility the resident's representative's contact information was obtained. The NHA said that nursing staff received initial training related to notification of changes upon new hire and annually. The NHA said RN #1 was verbally counseled and reeducated on 2/20/25 after the email was received from Resident #3's resident representative.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards of practice for one (#2) of two residents reviewed for dialysis out of 15 sample residents. Specifically, the facility failed to consistently and thoroughly complete the dialysis communication forms between the facility and the dialysis center for Resident #2. Findings include: I. Facility policy and procedure The Hemodialysis Policy, dated March 2019and revised April 2024, was provided by the nursing home administrator (NHA) on 2/26/25 at 11:42 a.m. via email. It revealed in pertinent part, This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The facility will monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment and will inform the attending practitioner and dialysis facility of the changes. The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse will ensure that the dialysis access site (AV (arteriovenous) shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit (an abnormal sound in the blood that can indicate a partial blockage in an artery) and palpating for a thrill (a vibration or buzzing sensation felt at the site where the artery and vein have been surgically connected to create an access point for hemodialysis). If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist. II. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included type 1 diabetes mellitus with hyperglycemia (unusually high blood glucose levels), stage four chronic kidney disease, tachycardia (abnormally fast heart beats), cerebral infarction (stroke), traumatic brain injury (TBI), seizures, unspecified cirrhosis of the liver, cognitive communication deficit and dependence on renal dialysis. The 1/21/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) of 11 out of 15. He did not reject care from staff. He used a front wheel walker to ambulate. He was independent with eating, and oral hygiene. He required set up or cleaning assistance with toileting. The MDS assessment indicated the resident received dialysis treatments. B. Resident interview Resident #2 was interviewed on 2/25/25 at 11:55 a.m. Resident #2 said he had attended dialysis for about six years. He said he went to dialysis three times per week. He said sometimes he forgot to return to the facility with his dialysis book that the facility sent him with on each visit. He said today (2/25/25) he did not remember where he left his dialysis communication book. He said at one time, his dialysis book was the color purple but now it is white and he said, who knows what color it is. C. Record review Review of Resident #2's February 2025 CPO revealed the following physician's orders related to dialysis: Resident #2 was to go to dialysis Tuesday, Thursday, and Saturday. Make sure the resident took his dialysis folder, ordered 2/25/25. Review of Resident #2's dialysis care plan, initiated 11/5/24, revealed the resident needed hemodialysis for the disease process. Interventions were to monitor weights for pre- and post-dialysis three times per week. -However, the care plan did not identify what disease process the hemodialysis was needed for. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's February 2025 medical treatment administration record (MAR) and treatment administration record (TAR) revealed the following: Make sure the resident takes his dialysis folder and snacks one time a day every Tuesday, Thursday, and Saturday for ESRD (end stage renal disease). The dialysis communication log books were provided by the interim director of nursing (IDON) on 2/26/25 at 2:19 p.m. Each log had three sections on one sheet of paper which revealed the following: The pre-dialysis section was to be filled in by the facility with the date and the resident's vital signs which included, temperature, pulse, respirations, blood pressure, weight and oxygen saturation levels. There was a section to write in the medications given to the resident prior to dialysis, and if a meal or snack was sent with the resident and if no, why not. A nurses' signature was required to validate that the information was completed. The middle section of the communication form was to be filled out by the dialysis center staff. The documentation was to include the amount removed from the resident (waste products and excess fluids from the blood), post-dialysis weight, if the dialysis was completed with a full cycle, and if not an explanation was to be given. Also included was any laboratory (lab) work completed and any issues with accessing graft or catheter. Medications given at dialysis were to be listed, along with any recommendations from the dialysis center. A nurses' signature from the dialysis center was required to validate the information. This section was returned with the resident to the facility. The post-dialysis section was to be completed by the facility when the resident returned after receiving dialysis. The post-dialysis section repeated all the vital signs to be recorded again as in the pre-dialysis section. The post-dialysis section further included the following questions: Any bleeding from the access site, was there a meal given at the resident's return, were there any new orders sent with the resident and were there any new skin issues. A nurses' signature was required to validate the post-dialysis information was completed. Resident #2's dialysis communication logs from 2/1/25 through 2/25/25 were provided by the social services assistant (SSA) on 2/26/25 at 1:20 p.m. The dialysis communication logs revealed the following: Resident #2 was scheduled to attend dialysis 11 times from 2/1/25 to 2/25/25. -The facility was not able to provide dialysis communication forms for 2/4/25, 2/8/25, 2/11/25, 2/13/25, 2/15/25 and 2/18/25. The five dialysis communication forms the facility was able to provide documented the following: On 2/1/25 all three dialysis communication form sections were fully completed. On 2/6/25 the pre-dialysis section did not include the medications given prior to dialysis, whether or not a meal or snack was sent with the resident and the resident's weight was not provided. The facility nurse did not sign the communication form to validate the information was completed. On 2/20/25 Resident #2 refused to go to his dialysis appointment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/22/25 the post-dialysis section information was not documented by the facility. On 2/25/25 the communication form was incorrectly dated. It was dated 2/24/25 instead of 2/25/25. The pre-dialysis section of the form did not include the medications given prior to dialysis, whether or not a meal or snack was sent with the resident and the resident's weight was not provided. The post-dialysis section was not documented on a separate form when the resident did not return with his dialysis log book that day. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 2/25/25 at 10:45 a.m. LPN #1 said he was the nurse today (2/25/25) for Resident #2. LPN #1 said he filled out the communication form log sheet and made sure Resident #2 took his dialysis log book to dialysis. -However the dialysis communication form was dated 2/24/25, instead of 2/25/25 (see record review above). LPN #1 said when a resident on dialysis returned from a dialysis center, the facility nurse was responsible for filling in the post-dialysis communication section on the daily sheet. LPN #1 said it was important to take a resident's vital signs when they arrived back at the facility to ensure the resident was doing well. LPN #1 said whatever the dialysis center wrote in their section was pertinent information for the nursing staff to read about the resident. LPN #1 said Resident #2 consistently had high blood sugars that needed to be closely monitored because he was on an insulin sliding scale which meant Resident #2 might need extra units of insulin to be administered if his blood sugars were high. LPN #1 said if Resident #2's blood sugars were high, insulin would be administered, and then after a waiting period, Resident #2 would be monitored again to see if his blood sugar levels came down from the administered insulin. He said if his blood sugars levels were over 400 the nurse was to immediately notify the physician, and let the physician determine what may be needed for the resident. The SSA was interviewed on 2/25/25 at 2:55 p.m. The SSA said it was brought to the facility's attention (during the survey) that Resident #2 did not return from dialysis with his communication log book. The SSA said she called the transportation company who said he left his book in their vehicle. The SSA said the book with the dialysis communication forms would be returned to the facility the following day on 2/26/25 between 10:00 a.m. and 12:00 p.m. The nurse practitioner (NP) was interviewed on 2/26/25 at 10:15 a.m. The NP said he had worked with Resident #2 for a few years. The NP said Resident #2 had erratic blood sugars. The NP said Resident #2 was a brittle diabetic which could cause him to have unpredictable blood sugar swings. The NP said Resident #2 had been hospitalized at times due to this dangerous condition. The NP said Resident #2 had been losing weight which also needed to be monitored. The IDON was interviewed on 2/26/25 at 3:00 p.m. The IDON said she did not know where all of Resident #2's dialysis communication logs were for the month of February 2025. She said what was found were only four sheets that were in his dialysis book. The IDON said all three sections of the dialysis communication form should be filled out completely for each resident that attended dialysis. The IDON said she would begin an education about dialysis communication for all of the nursing staff which would begin on 2/26/25. (continued on next page)

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F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The IDON said dialysis binders for the residents were purple. She said Resident #2's lost binder was returned to the facility today (2/26/25)per the SSA's request to the transportation company. IDON said the returned binder was white not purple and she did not know why. She said she was unaware another resident's dialysis binder was white also. The IDON said yesterday (2/25/25) when Resident #2 returned from dialysis, the information for the post-dialysis information was not written down on a separate form to document his vital signs were taken. The IDON said it was important for the facility to fill in the post-dialysis section as well as read what the dialysis center wrote in their section on the log sheet.

The IDON said Resident #2 rarely refused to go to his dialysis appointments. The IDON said on 2/20/25 Resident #2 refused to go to dialysis because he was tired from a hospital stay on 2/19/25.

The IDON said if she was able to locate the missing communication log sheets for Resident #2 she would provide them via email.

-However, the facility did not provide any further dialysis communication forms for Resident #2.

IV. Facility follow up

On 2/27/25 at 12:46 p.m. the NHA provided a policy performance improvement plan (PIP) for hemodialysis via email. On 2/27/25 at 1:23 p.m. the NHA provided, via email, the PIP education that was given to the nursing staff at the facility.

The education included a sample of how the dialysis communication form was to be correctly filled out. The NHA further provided the five question quiz provided to the nursing staff about dialysis. The NHA said all dialysis residents from now on would have a uniform (same) color binder.

The PIP documented the following in pertinent part:

Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.

Continuous monitoring and oversight before, during, and after dialysis treatments, including observation of the resident's condition, monitoring for complications, implementing appropriate interventions, and using infection control practices.

Regular communication and collaboration with the dialysis facility regarding dialysis care and services.

The facility will monitor changes in behavior that could impact dialysis safety before and after treatments and communicate these changes with the attending physician and dialysis facility.

Immediate education initiated to all relevant nursing and facility staff on the dialysis policy's guidelines, highlighting pre/post dialysis assessments, completion of dialysis flow sheets, maintenance of binders and communication with dialysis center and transportation.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation of dialysis-related care (binders/assessments) will be reviewed 6 (six) times a week (Monday through Saturday) for accuracy and completeness in collaboration with dialysis providers. Trends will be discussed in quality assurance and performance improvement (QAPI) committee meetings monthly until substantial compliance is achieved. The staff education documented the following in pertinent part: It is very important that the appropriate dialysis communication form is filled out pre- and post-dialysis. Attached is a dialysis communication form and how it is to be filled out. The form will be sent with the resident and returned with the resident. Any new doctor orders will be written on this form. Post-dialysis vital signs must be done immediately upon return. Make sure fistula or chest port is observed upon return and documented in a nurse's note.