STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Lodge Health and Rehabilitation Center	1637 29th Avenue Pl Greeley, CO 80634

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48113 Based on record review and interviews, the facility failed to ensure level II preadmission screening and resident review (PASRR) were completed for one (#33) of two residents out of 32 sample residents reviewed for PASRR to gain and maintain their highest practical medical, emotional and psychosocial well-being. Specifically, the facility failed to follow PASRR level II recommendations for Resident #33. Findings include: I. Facility policy and procedure The PASRR completion policy, revised 2/23/24, was provided by the quality mentor (QM) on 4/11/24 at 11:40 p.m. It read in pertinent part, If the resident has a PASRR Level II, the community is responsible for ensuring that any recommendations from the PASRR Level II are implemented and care planned for the resident. II. Resident status Resident #33, age above 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included history of falling, weakness, generalized anxiety disorder, major depressive disorder, recurrent, mild, unspecified symptoms and signs involving cognitive functions and awareness. The 1/13/24 minimum data set (MDS) assessment did not document the resident's level II PASRR level II for a serious mental illness. It revealed that the resident had severe cognitive impairments with a brief interview of mental status (BIMS) score of five out of 15. III. Record review Review of the resident's PASRR level II dated 10/21/22 documented the resident had cognitive deficits that were very present during the meeting with the evaluator. The evaluator concluded that cognitive decline appeared to be the primary issue from the observations and assessment. Resident #6 did not have a history of mental health services or behavioral health support services. The evaluator noted a primary diagnosis of unspecified neurocognitive disorder and recommended formal neuropsychological testing to understand the cause or other processes that were causing cognitive declines (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of the comprehensive care plan dated 2/22/24 did not document the resident's PASRR level II screening and specialized services recommendations for mental illness. The social services progress notes reviewed from 10/21/22 through 4/11/24 did not document that the facility had reached out to a mental health provider to establish services for neuropsychological testing. Review of the April 2024 CPO failed to show an order for the resident to be seen for neuropsychological testing. IV. Staff interviews The social services director (SSD) was interviewed on 4/11/24 at 10:54 a.m. The SSD said the PASRR recommendations were not followed up on according to her review of the medical record. She said neuropsychological testing was not completed because there had been issues with the behavioral health provider that the facility had worked with, however, the behavioral health facility that the facility worked with did not conduct neuropsychological testing. She said she did not know why there was not a physician's order for neuropsychological testing. She said she would audit all resident PASRRs and ensure all recommendations were followed and maintain a spreadsheet to track PASRRs due and follow up on all recommendations. The director of nursing (DON) was interviewed on 4/11/24 at 11:45 a.m. The DON said the facility should follow up on all PASRR recommendations to ensure residents maintained their quality of life. The nursing home administrator (NHA) was interviewed on 4/11/24 at 11:45 a.m. She said education, training and audits would be put in place to ensure the facility maintained tracking of PASRR evaluation completion and follow up on recommendations.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to ensure that activities of daily living (ADL) for dependent residents were provided for one (#31) of two residents out of 32 sample residents. Specifically, the facility failed to provide eating assistance for a resident who required supervision and cueing and who was at high risk for weight loss. Finding include: I. Facility policy and procedure The Weight Management policy and procedure, reviewed 2/29/24, was provided by the quality mentor (QM) on 4/11/24 at 11:39 a.m. It read in pertinent part, Residents are monitored for weight change on a regular basis. Results are reviewed and analyzed by the facility for interventions as appropriate. Residents identified at risk for weight change will have interventions implemented to minimize the risk for additional weight change included in their plan of care. This may include supplements, registered dietician (RD) evaluation and assisted dining. II. Resident #31 A. Resident status Resident #31, age 82, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease and severe protein malnutrition. The 1/2/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with deficits in short and long term memory according to the staff interview for mental status. She was dependent on staff for toileting and personal hygiene. She required substantial/maximal assistance with bed mobility, transfers and required supervision with touch assistance and cueing for eating. B. Observations During a continuous observation on 4/8/24, beginning at 11:40 a.m. and ending at 12:30 p.m., Resident #31 was sitting in the dining room in a wheelchair at a table alone. At 12:00 p.m. Resident #31 was served her meal which included pureed meat, vegetables and mashed potatoes. She was also served ice cream and a whole banana. The staff uncovered the resident's plate, opened the ice cream up and peeled the banana. The staff then went to assist other residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:05 p.m. Resident #31 picked up her fork and used the fork to pick at what was on the plate. She ate one to two small mouthfuls of meat and vegetables. She then began to eat the ice cream and finished the ice cream. -Staff were not observed assisting or cueing the resident with eating. At 12:30 Resident #31 remained in the dining room. She had consumed all of the ice cream. She had not eaten her meal or the banana. Staff assisted Resident #31 back to her room. -Staff did not ask Resident #31 if she was still hungry or attempt to offer the resident a bite of food prior to taking the resident back to her room. -Staff did not offer an alternative to the resident when she did not eat the food on the plate in front of her. During a continuous observation on 4/10/24, beginning at 12:00 p.m. and ending at 12:40 p.m., Resident #31 was again sitting in the dining room in a wheelchair. At 12:18 p.m. Resident #31 was served a plate that contained pureed meat, vegetable and mashed potatoes. She was also served a cup of ice cream and a peeled banana.The staff uncovered the resident's plate and opened the ice cream. The staff then went to assist other residents. At 12:20 Resident #31 picked up a spoon and started eating the ice cream. Resident #31 did not eat any of the pureed meat, pureed vegetables, mashed potatoes or banana. -The staff did not assist or cue the resident with her meal. At 12:40 p.m. Resident #31 finished the ice cream. Resident #31 did not take any bites of the pureed meat, pureed vegetables, mashed potatoes or banana. -The staff did not attempt to assist or cue the resident with her meal. -The staff did not offer the resident any food alternatives or additional food items when the resident did not eat the food on the plate in front of her. C. Record review The nutrition care plan, initiated 3/13/23 revised 9/12/23, indicated Resident #31 was at an increased nutritional risk related to Alzheimer's disease and severe protein calorie malnutrition. The interventions included monitoring and reporting signs of dysphagia (inability to swallow), monitoring signs of malnutrition (muscle wasting, significant weight loss), offering preferred foods, offering snacks, encouraging the resident to request large portions of foods she enjoyed and encouraging juice and milk with meals for added calories. The functional abilities/self care care plan, initiated 3/16/23 and revised 3/28/24, indicated Resident #31 had a decline in self care function related to Alzheimer's disease and rheumatoid arthritis. The interventions included providing set-up assistance and clean-up assistance for meals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of the comprehensive care plan did not reveal the care plan had been updated to include the resident's increased need for feeding assistance. A comprehensive review of meal assistance documentation for Resident #31 revealed inconsistent eating assistance. The meal assistance documentation record from 3/8/24 to 4/8/24 revealed she required set up assistance 24 times, required supervision/touch assistance/cueing four times, required partial/moderate assistance two times, was dependent two times and not applicable eight times. -There was nothing documented on the record for meal assistance 47 times from 3/8/24 to 4/8/24. III. Staff interviews The registered dietitian (RD) was interviewed on 4/11/24 at 10:11 a.m. The RD said she had noticed Resident #31 recently needed more supervision, encouragement and cueing for her oral intake during meals. She said Resident #31 was at high risk for weight loss and had recently lost weight, even though overall weight was trending up. She said the staff should have encouraged oral intake during meals. Certified nurse aide (CNA) #1 was interviewed on 4/11/24 at 10:56 a.m. CNA #1 said staff assisted with just the set up of Resident #31's meal tray. She said staff did not provide assistance or cueing for Resident #31 at meals. She said Resident #31 was able to feed herself. CNA #1 said Resident #31 would only eat, at most, 25% of her meal. She said any feeding assistance required should be documented in the electronic medical record point of care system. She said residents who were at risk for weight loss should be cued and assisted with their meals and it should be documented every meal. The director of nursing (DON) was interviewed on 4/11/24 at 12:00 p.m. The DON said a resident that required supervision and cueing, especially resident's at risk for weight loss should have received assistance in the resident dining room. She said Resident #31 should have received staff cueing and supervision during her meals.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to ensure two (#35 and #51) out of two residents out of 32 sample residents received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to: -Follow hospital physician orders to remove Resident #35's cervical neck brace after six weeks; -Monitor the skin under Resident #35's cervical neck brace; -Ensure Resident #35 was transported to and attended her neuro-orthopedic doctor' s appointment; and, -Support and position Resident #51 in her wheelchair properly. Findings include: I. Professional reference The Hull University Hospital Guide to Wearing Your Cervical Hard Collar, dated 3/19/21, was retrieved from https://www.hey.nhs.uk/patient-leaflet/guide-wearing-cervical-hard-collar/ on 4/16/24. It read in pertinent part, A hard collar is a device designed to limit movement of your neck. It is most commonly used to manage spinal fractures. It is important the collar is removed daily to be able to wash, dry and check your skin. However, when you no longer require your collar you will be advised to gradually remove it and you will be provided with an exercise program to strengthen your muscles again. II. Resident #35 A. Resident status Resident #35, over the age of 65, was admitted on [DATE] and readmitted [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included fracture of second and fourth cervical vertebra (neck fracture), rhabdomyolysis (damaged muscles), congestive heart failure, and history of falling. The 2/16/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. She required substantial/maximal assistance with lower body dressing and partial/moderate assistance for toileting, bathing, upper body dressing, and bed mobility. Transfers required supervision or touch assistance and walking 10 feet once standing. B. Resident interview and observation (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35 was interviewed on 4/8/24 at 1:50 p.m. Resident #35 said he said she had fallen at home in January 2024 and fractured her neck. She was observed wearing a rigid cervical neck brace. Resident #35 was observed on 4/10/24 at 7:28 a.m. She was seated in her wheelchair in the dining room with her rigid cervical neck brace on. Resident #35 was interviewed again on 4/11/24 at 10:34 a.m. She said her rigid cervical neck brace was uncomfortable but was told not to take it off at all. Resident #35 said she did not know the date of when she could remove it. Resident #35 said the neck brace did not feel very good and it was difficult to sleep with the neck brace due to it being hard. Resident #35 said she had no pain at rest but if she moved she had moderate pain. The neck brace padding around her chin and neck was stained with brown and yellow marks. -Resident #35 began wearing the rigid cervical neck brace on 1/21/24. She had been wearing the brace for 12 weeks. C. Record review The hospital discharge documents (admitted to hospital 1/14/24 and discharged [DATE]) revealed instructions from the doctor in pertienent part, You will need to wear a cervical collar at all times for six weeks. You will have another collar for showers only. -However, these orders were never entered into the facility orders upon the resident' s admission. Facility nurse practitioner (NP) #1' s new admission note, dated 1/22/24, revealed the reason for the appointment was the resident was status post acute hospitalization for a fall resulting in cervical fractures. The assessment and plan documented the resident was neurologically intact, the fractures were stable and there were no ligamentous injuries. The neurosurgeon recommended conservative management with a rigid collar. Aspen cervical collar was to be worn at all times for six weeks. Follow-up with neurosurgery as instructed. -However no physician orders were entered into the facility orders to confirm the cervical collar was to be worn for six weeks. The physical therapy (PT) evaluation dated 1/22/24 revealed the resident was recently hospitalized following a fall and hitting the back of her head. The resident was diagnosed with C2 and C4 (second and fourth cervical vertebra) fractures which were treated conservatively with a cervical collar for six weeks. The cervical collar was to be worn at all times. -The PT was aware Resident #35 was to wear the cervical collar for six weeks but did not take steps to ensure the facility had physician orders in place to notify the staff when the cervical could be removed after the six week time frame. The occupational therapy (OT) evaluation, dated 1/22/24, revealed the resident was recently hospitalized following a fall and hitting the back of her head. She was diagnosed with C2 and C4 fractures and was treated conservatively with a cervical collar for six weeks at all times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The OT was aware Resident #35 was to wear the cervical for six weeks but did not take steps to ensure the facility had physician orders in place to notify the staff when the cervical collar could be removed after the six week time frame. The musculoskeletal care plan, initiated 1/28/24, revealed the resident had alteration in status related to fractures of the second and fourth cervical vertebra. The resident wore a rigid cervical collar at all times. Interventions included: assisting the resident with the use of supportive devices (rigid c-collar) as recommended, analgesics (pain medications) as ordered by the physician, monitor and documenting for side effects and effectiveness of pain medications, monitoring and documenting for risk of falls, educating the resident/family/caregivers on safety measures that need to be taken in order to reduce a risk of falls. -However, the care plan failed to identify how long the resident was supposed to wear the brace, how to clean the brace and showering precautions. The April 2024 CPO revealed the following physician orders: Bathing every day shift every Monday and Thursday, order date 1/23/24. -However, the physician's order did not include the use of a special shower collar during showers. Skin monitoring: remove the cervical collar at bedtime to assess skin for any breakdown, then reapply cervical collar, ordered on 2/23/24. -However, the resident was admitted on [DATE] and there was no documentation indicating skin monitoring had been completed under her cervical collar for 33 days. Cervical collar in place at all times. Monitor placement every shift. Cervical collar to be re-evaluated by neurosurgeon at appointment on 3/28/24, order date 3/25/24. -However, the order was added two months after the resident was admitted and the facility failed to take the resident to her scheduled neurosurgeon appointment. Cervical (neck) X-ray, order date 4/11/24 (during the survey process). -Resident #35 had not been taken to any neuro-orthopedic appointment check-ups since admission. -The facility continued to require Resident #35 to wear her rigid cervical neck brace due to lack of follow-up. III. Staff interviews The quality mentor (QM) was interviewed on 4/10/24 at 4:10 p.m. The QM said the facility called the orthopedic office today (4/10/24) for Resident #35 but the physician' s office did not know when the hard neck brace could be removed. The QM said no one at the orthopedic office knew when Resident #35 could remove the neck brace. She said the facility did not know either. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The QM said the orthopedic office confirmed that Resident #35 had had an appointment set up with them on 3/8/24 but Resident #35 did not show up for the appointment. The QM said the facility transportation department had set up the original 3/8/24 appointment but she did not know why the appointment was missed or why no one at the facility realized that she had missed the appointment. The QM said she scheduled a new appointment for 5/30/24 after it was brought to her attention that Resident #35 did not have a follow up appointment with the neurosurgeon. The QM said she called Resident #35' s orthopedic doctor but he did not answer and she had not heard back from him. The QM said Resident #35 had not seen her orthopedic doctor since she had been admitted to the facility. The QM said the orthopedic office was not able to answer any questions about Resident #35' s cervical neck brace removal date because they had never seen her as a patient. The director of nursing (DON) was interviewed on 4/11/24 at 11:05 a.m. She said the process for keeping track of casts, boots, slings and braces was to start by looking at the admission orders and to look for follow-up physician appointments. The DON said she would also look at the care plan to see if the device had a date it could be discontinued or be a permanent type of brace. The DON said she would want all the information and details on the care plan so the staff were aware of the care and treatment for the brace. The DON said a physician' s order would need to be obtained for the device to have a start and end date. She said physician orders needed to be included for medical appointments that included the date and time. The DON reviewed the hospital discharge orders for Resident #35 and said the hospital physician documented the cervical collar needed to be worn at all times for six weeks. She said the hospital discharge information also documented the resident would have another collar to wear during showers. The DON said the duration of the cervical collar and the guidance for the shower collar should have been documented as a physician order and in the resident' s plan of care. The DON said if the physician order was in the resident' s medical record it would have triggered the nurses to call the physician for confirmation when the six weeks was completed. The DON said the hospital discharge orders were not entered into the resident' s medical records correctly regarding the cervical collar and removal after six weeks. She did not know the resident had a collar to wear during the showers but would find out more information. The DON said the admission nurse did not confirm the orders. The DON said the admission nurse did not make the follow-up appointment. The DON said she would complete an audit of all residents that had a cast, boot, sling or brace. The QM was interviewed again on 4/11/24 at 11:43 a.m. She said the facility NP had ordered a cervical x-ray and planned to send the results to the orthopedic physician in hopes he would be able to make a decision about when the rigid cervical collar should be removed for Resident #35. The QM said she had called the resident' s physician yesterday (4/10/24) regarding the cervical neck collar but he never called her back. The QM said Resident #35 had never been a patient of this physician before. The QM said she was not sure which physician had written the discharge orders from the hospital for wearing the cervical collar for six weeks. The QM said she was unsure why the facility did not follow up with the transportation company when they did not take Resident #35 to her appointment on 3/8/24. She said the facility should have followed up after the resident missed her appointment and scheduled a new appointment for the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51, age less than 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included anoxic brain damage, heroin overdose and contractures bilateral upper extremities. The 3/15/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent with eating, toileting, personal hygiene, bed mobility and transfers. C. Observations On 4/8/24 at 12:00 p.m. Resident #51 was sitting in the dining room in a wheelchair leaning over her wheelchair to the left side. Staff was feeding the resident while the resident was slouched over the left side of her wheelchair. Staff did not offer or attempt to reposition the resident upright prior to assisting the resident with her meals. On 4/9/24 at 12:30 p.m. Resident #51 was sitting in the dining room in a wheelchair leaning over her wheelchair on the left side. Staff did not offer or attempt to reposition the resident upright prior to assisting the resident with her meal. D. Resident interview Resident #51 was interviewed on 4/9/24 at 9:00 a.m. Resident #51 said she was leaning to the side in her wheelchair. She said staff picked her up by her pants to help reposition her in her wheelchair. She said they had not assessed her positioning in the wheelchair she had since she had received it more than a year ago. E. Record review The functional abilities/self care/mobility care plan, initiated on 5/3/22 and revised on 3/14/24, indicated Resident #51 had a self care/mobility deficit and required total care related to her history of an overdose and a motor vehicle accident. Interventions included she was wheelchair dependent and required a mechanical lift for transfers and physical and occupational evaluation and treatment per physician orders. The fall care plan, initiated 2/10/22 revised 7/14/22, indicated Resident #51 was at risk for falls related to her total dependence on care and contractures. Interventions included physical therapy to evaluate and provide treatment as ordered or as necessary and the resident was awaiting a new personal adaptive wheelchair on 10/24/22. -A review of the resident's medical record did not reveal an assessment of the resident's wheelchair positioning had not been completed in the past year. F. Staff interviews (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of rehabilitation (DOR) was interviewed on 4/10/24 at 9:30 a.m. The DOR said Resident #51 received a new personal adaptive wheelchair more than a year ago. He said he was not aware of any issues and had not received any concerns from staff regarding her positioning in the wheelchair. He said her new wheelchair had not been evaluated for positioning since she had received it. He said since he observed her current positioning leaning to the left in the wheelchair, he would get an order to evaluate her wheelchair. He said this should be done to help keep the resident in the correct alignment. Registered nurse (RN) #2 was interviewed on 4/11/24 at 10:45 a.m. RN #2 said she knew Resident #51 well and she had noticed that she had been leaning to one side in her wheelchair. She said Resident #51 had her current wheelchair for over a year. She said she did not think it had been evaluated for positioning. She said the issue had been informally discussed but it had not been brought to the attention of therapy for the wheelchair to be evaluated. She said this should be done to help minimize potential issues with incorrect positioning in the wheelchair, such as skin or feeding issues. The director of nursing (DON) was interviewed on 4/11/24 at 2:00 p.m. She said dependent residents that were wheelchair bound and had positioning issues should be evaluated by therapy for positioning. She said if staff noticed positioning issues with Resident #51 in her wheelchair, the concerns should have been addressed with therapy.

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F 0689 Level of Harm - Minimal harm or potential for 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** 48113 Based on observations, record review and interviews, the facility failed to ensure two (#33 and #35) of two residents reviewed for accidents out of 32 sample residents received adequate supervision to prevent accidents. Specifically, the facility failed to: -Complete a root cause analysis and implement person centered fall interventions for Resident #33 and Resident #35; and, -Ensure a registered nurse (RN) completed an assessment after Resident #33 sustained a fall. Findings include: I. Facility policy and procedure The Fall management policy and procedure, revised 2/29/24, was provided by the quality mentor (QM) on 4/11/24 at 11:39 a.m. it read in pertinent part, A fall reduction program will be established and maintained, to assess all residents to determine their risk for falls. A plan of care will be implemented based on the resident's assessed needs. Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Please note interventions are to be re-evaluated when a resident falls for efficacy. Assess the environment and make appropriate changes, bed in lowest position, placement of furniture, lighting, personal items within reach, non-slip footwear, night light, walker, wheelchair within reach if applicable. The call light and fluids should be within reach of the resident. Positioning devices (low bed, fall mat, defined perimeter mattress). Complete a thorough analysis of fall - time of day, location of fall, causative factors. Identify whether the interventions were in place at the time of the fall. Interview staff and resident(s) if able to identify potential causative factors. II. Resident #33 A. Resident status Resident #33, over the age 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included history of falling, weakness, generalized anxiety disorder, major depressive disorder, recurrent, mild, unspecified symptoms and signs involving cognitive functions and awareness. According to the 1/13/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five of 15. The resident suffered two falls, both with injury since the previous quarterly assessment. The resident was independent with most activities of daily living (ADL). She required supervision from one person for locomotion on and off the unit. The resident required a walker for mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations On 4/10/24 at 8:48 a.m. Resident #33 was lying on her bed with her eyes closed. Her call light was behind the bed on the floor and not within reach of the resident.The resident did not have non-skid socks on her feet. The resident's socks were on the floor near the end of the bed. C. Record review The fall care plan, initiated on 10/20/22 and revised 4/8/24, revealed the resident was at risk for falls related to gait and balance problems and vision and hearing problems. The interventions included: ensuring the resident wore appropriate footwear when ambulating or mobilizing in a wheelchair (10/20/22), ensuring the call light was within reach (11/10/22), encouraging the resident to use the call light when she needed assistance (11/10/22), ensuring the resident had a safe environment with floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, ensuring the bed is in a low position at night; ensuring there were handrails on the walls (11/10/22), ensuring personal items within reach (11/10/22), encouraging the resident to wear non-skid socks (3/6/24) and providing frequent rounding. conducting a room air study to reduce risk of falling with oxygen tubing (12/12/23). The care plan revealed the resident chose not to use call light (12/4/23). The 12/26/23 provider progress note documented to expect unavoidable falls due to the residents' underlying comorbidities. -However, the facility failed to determine a root cause analysis of the resident's falls to implement person centered fall interventions to prevent further falls. The 4/12/23 fall risk assessment revealed the resident was at high risk for falls. 1. Fall incident on 3/16/24 - unwitnessed The 3/16/24 nursing progress note documented by a licensed practical nurse (LPN) at 5:01 p.m. revealed the resident was assessed with no noted injuries. A neurological exam was completed and was within normal limits. The residents' vital signs were within normal limits. The resident's primary care physician, power of attorney, and the director of nursing (DON) were notified of the fall. Neurological checks were initiated per facility protocol. The 3/16/24 nursing progress note documented by a LPN revealed the resident was found on her back on the floor in her bedroom. The resident said she was trying to self transfer and fell to the floor. -The facility failed to conduct a root cause analysis of the resident's fall to determine a person centered fall interventions. -A review of the resident's comprehensive care plan did not reveal the care plan was updated with person-centered fall interventions after she sustained a fall on 3/16/24. -A review of the resident's medical record did not reveal the resident was assessed by a RN after sustaining an unwitnessed fall on 3/16/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Fall incident on 4/5/24 - unwitnessed The 4/5/24 nursing progress note documented by a LPN at 9:32 p.m. revealed the resident had an unwitnessed fall. Resident 33's roommate alerted the staff that the resident had fallen. Resident #33 was found lying on her right side. The nurse assessed and there was no apparent injury. The resident was confused and unsure how she fell . The resident was assisted back to bed. The on-call provider, the resident's nephew and the nurse management was notified of the fall. -The facility failed to conduct a root cause analysis of the resident's fall to determine a person centered fall interventions. -A review of the resident's comprehensive care plan did not reveal the care plan was updated with person-centered fall interventions after she sustained a fall on 4/5/24. -A review of the resident's medical record did not reveal the resident was assessed by a RN after sustaining an unwitnessed fall on 4/5/24. 3. Fall incident on 4/11/24 - unwitnessed The 4/11/24 nursing progress note documented by an LPN at 11:59 p.m. revealed the resident had an unwitnessed fall. Resident 33's roommate alerted the staff that the resident was on the floor. Resident #33 was found sitting on the side of her bed. The nurse assessed and there was no apparent injury. The resident was confused and unsure how she fell . The neurological checks were continued. The resident was assisted back to bed. The on-call provider, the resident's nephew and the nurse management was notified of the fall. -The facility failed to conduct a root cause analysis of the resident's fall to determine a person centered fall interventions. -A review of the resident's comprehensive care plan did not reveal the care plan was updated with person-centered fall interventions after she sustained a fall on 4/11/24. -A review of the resident's medical record did not reveal the resident was assessed by a RN after sustaining an unwitnessed fall on 4/11/24. D. Staff interviews LPN #1 was interviewed on 4/11/24 at 9:51 a.m. LPN #1 said Resident #33 was at high risk for falls. She said the resident had several recent unwitnessed falls in her room near her bed. LPN #1 said the resident required frequent monitoring. LPN #1 said the resident needed supervision when ambulating as she forgot she could not walk without her walker and she would attempt to walk without assistive devices which put her at risk for falling. She said the resident needed to wear non-slip socks. LPN #1 said the resident had frequent falls in her room at night. She said the facility needed to explore other interventions to prevent the resident from falling. The director of nursing (DON) was interviewed on 4/11/24 at 4:25 p.m. The DON said Resident #33 often got up without assistance. She said Resident #33 sometimes forgot to use her walker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said staff should offer to help the resident to lie down and place the bed in the lowest position whenever the resident went to bed. The DON said staff needed to ensure the resident's call light and personal belongings were within reach of the resident The DON said the facility needed to follow the person centered fall interventions to help prevent the resident from further falls. The DON said the nursing fall assessments were not able to be found aside from progress notes after each fall which said an LPN assessed the resident. The DON said no new interventions were implemented after each fall from 3/16/24 through 4/11/24 and the interdisciplinary team (IDT) was pending review to be completed after survey exit. The DON said she would provide education, training and audits for falls to ensure immediate interventions were put in place after a fall by nursing care staff on duty. She said she would ensure care plans were updated with person centered interventions after each fall. She said she would implement a monitoring system to ensure interventions were being followed by staff, a RN completed the post fall assessment, and ensure the IDT was completed by the next working day. The nursing home administrator (NHA) was interviewed on 4/11/24 at 4:45 p.m. The NHA said the facility would implement a fall action plan to ensure nursing care staff was provided with education and training for falls. She said the facility would implement audits to ensure immediate interventions were put in place after a fall by nursing care staff on duty. She said she would ensure care plans were updated with person centered interventions after each fall and ensure the interventions were being followed by staff. She said the facility would ensure a RN completed the post fall assessment and ensure the IDT completed a root cause analysis of the fall that included a person centered fall interventions. 43950 III. Resident #35 A. Resident status Resident #35, age greater than 65, was admitted on [DATE] and readmitted [DATE]. According to the April 2024 CPO, diagnoses included fracture of second and fourth cervical vertebra (neck fracture), rhabdomyolysis (damaged muscles), congestive heart failure (CHF) and history of falling. The 2/16/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of eight out of 15. She required substantial/maximal assistance with lower body dressing and partial/moderate assistance for toileting, bathing, upper body dressing, and bed mobility. She required supervision or touch assistance for transfers and walking 10 feet once standing. B. Resident interview and observation Resident #35 was interviewed on 4/8/24 at 1:50 p.m. Resident #35 said she had fallen backwards at home in January 2024 and fractured her neck. She was observed wearing a rigid cervical neck brace. She did not recall her fall at the facility in February 2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35 was interviewed again on 4/11/24 at 10:34 a.m. Resident #35 said she did not recall her fall out of bed. She said she had just had a shower the morning of the fall. There was a sign on the wall that said Call light: press the red button when: pain, hunger, help, bathroom. Resident #35 was seated in a reclining chair in the middle of her room. -Her call light was not within reach. The call light was hooked onto her pillow that was on her bed. C. Record review Resident #35's fall care plan, initiated on 1/21/24 and revised on 2/16/24, revealed the resident was at risk for falls related to cervical fractures, CHF and chronic fatigue. Interventions included: -Be sure the resident's call light was within reach and encourage her to use it for assistance as needed. The resident needed prompt response to all requests for assistance, initiated 1/21/24, revised 1/27/24. -The resident needed a safe environment with a high-low bed in low position while she was in bed, initiated 1/21/24, revised 1/27/24. -Ensure resident was wearing appropriate footwear when ambulation or mobilizing in wheelchair, initiated 1/21/24, revised 1/27/24. -PT(physical therapy) evaluation and treatment as ordered or PRN (as needed), initiated 1/21/24. -Review information on past falls and attempt to determine the cause of falls. Record possible root causes. After review remove any potential cause if possible. Educate resident/family/caregiver as to causes, initiated 1/21/24, revised 1/27/24. -The care plan failed to document any new or revised interventions following the residents' fall on 2/11/24 to help prevent future falls. The 2/11/24 alert note revealed a CNA (certified nurse aide) alerted the nurse at 7:01 a.m. that the resident was on the floor. Resident #35 was found on the floor next to her bed. The bed was in the highest position. The resident complained of back and right hip pain. The resident was unable to verbalize what happened or how she ended up on the floor. The note documented that due to her recent fall at home and a cervical spine fracture, the nurse did not attempt to move the resident and was unable to get vital signs due to signs of trauma. EMS (emergency medical services) arrived at the facility and straightboard lifted the resident onto the gurney and took her to the hospital for evaluation. The PCP (primary care provider), resident's son and DON (director of nursing) were notified. Report was called into the hospital ED (emergency department) charge nurse. The resident's medication list, facesheet, and MOST (medical orders for scope of treatment) form were sent with the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/12/24 nursing progress note revealed the resident was readmitted to the facility at 4:15 p.m. The resident was in a facility wheelchair with foot pedals in place and accompanied by a transportation coordinator. Resident #35 was alert and oriented to person. The current vital signs were the following: 109/64 blood pressure, 93 heart rate, 98.0 temperature, 94% oxygen saturation on 2 liters per minute of oxygen. A skin assessment was completed. The RN (registered nurse) asked the resident if it was okay to assist the resident to sit in front of the nurses station to which she nodded yes. The resident was currently in front of the nurses station wearing a neck brace and no complaint of pain or discomfort at the time. The medical doctor was notified about the resident's arrival back to the facility. The resident's medications were reviewed. Review of the hospital records revealed the following documentation: The 2/11/24 emergency room report revealed in pertinent part, the resident had an unwitnessed four foot fall out of bed. The nursing facility staff reported the resident was found on the ground and had complaints of right hip and neck pain. The resident denied hitting her head or losing consciousness. The resident did not recall the events leading up to the fall. EMS reported the resident was alert and oriented and reported to be at baseline by nursing staff. The resident was reportedly on 2 liters per minute of oxygen via nasal cannula continuously. The resident was found after the fall without her oxygen and hypoxic (deprived of adequate oxygen). The cervical collar was in place from previously known cervical vertebral fractures. The 2/11/24 hospital CT (computer tomography) scans and X-rays were negative for new fractures or dislocations. D. Facility's investigation of Resident #35's fall on 4/10/24 The fall investigation was provided by the nursing home administrator (NHA) on 4/10/24 at 12:51 p.m. It revealed the resident was found on the floor next to her bed on 2/11/24. The root cause was determined to be the resident was attempting to self-transfer. The resident had the cervical collar intact. The floor nurse notified the physician and EMR for possible trauma. The interventions included leaving the cervical collar in place, calling EMS to evaluate and send to ED for further assessment and educating the resident and floor staff to keep the resident's bed in low position with the call light within reach. The investigation documented the resident would continue with PT, occupational therapy (OT) and speech therapy (ST) as ordered. The physician and resident's son were notified of the fall. -However there were no staff interviews conducted during the investigation or new interventions added following the residents' fall to help prevent future falls. The resident's bed was not in a low position at the time of the fall. E. Staff interviews The DON was interviewed on 4/11/24 at 11:26 a.m. The DON said Resident #35's fall care plan interventions included keeping the resident's bed in the lowest position. The DON said the staff should have checked on the resident's bed frequently to ensure it was in the lowest position. The DON said the staff needed to ensure to return the bed to the lowest position after completing care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said a completed fall investigation should include staff interviews, including the nurse, to help determine the root cause of the fall and appropriate new fall interventions. The DON said after a fall, immediate new interventions should be put in place to help prevent future falls and increase resident safety. The DON reviewed Resident #35's care plan and said a new intervention was not added following her fall on 2/11/24 and being sent to the hospital for evaluation. The DON said a person centered fall intervention for Resident #35 should have been updated on her care plan after she sustained a fall. The DON said it was important to implement new interventions in the care plan after a fall to prevent more falls from occurring again.The DON said she was going to complete fall education with the staff regarding the post fall process and procedure.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and interviews, the facility failed to ensure residents were free from significant medication errors for two (#51 and #70) of five residents reviewed for significant medication errors out of 32 sample residents. Specifically, the facility failed to: -Ensure Resident #51 received the correct medications by ensuring the correct resident was identified before administering another resident's (Resident #20) medications; -Ensure Resident #51 had documentation, monitoring and follow up for possible adverse outcomes after receiving multiple wrong medications; and, -Ensure Resident #70 was given a scheduled opioid medication according to physician orders. Findings include: I. Professional reference [NAME], A., [NAME], L. M. (September 5, 2022). Nursing Right of Medication Administration. Stat Pearls. National Library of Medicine was retrieved on 4/16/24 from https://www.ncbi.nlm.nih.gov/books/NBK560654/. It read in pertinent part, Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. It is a standard during nursing education to receive instruction as a guide to clinical medication administration and upholding patient safety known as the five rights of medication administration. Right patient - ascertaining that a patient being treated is, in fact, the correct recipient for whom medication was prescribed. This is best practiced by nurses directly asking a patient to provide his or her full name aloud, checking medical wristbands if appropriate. Depending on the unit that a patient may be in, some patients may not wear wrist bands or may have altered mentation to the point where they are unable to identify themselves correctly. In these instances, nurses are advised to confirm a patient's identity through alternative means with appropriate due diligence. Right time - administering medications at a time that was intended by the prescriber. A guiding principle of this right is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms. II. Facility policy and procedure (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration policy and procedure, reviewed 2/29/24, was provided by the director of nursing (DON) on 4/10/24 at 9:51 a.m. It read in pertinent part, Be sure you have the right resident before administering the medication by means of a photograph identification (ID), bracelet ID on resident or bracelet ID on walker/wheelchair, verification with another staff member familiar with the resident. If the resident is alert and oriented you can verify with the resident by having the resident state their full name. The Adverse Consequences and Medication Errors policy and procedure, reviewed February 2023, was received from the DON on 4/10/24 at 4/10/24 at 9:51 a.m. It read in pertinent part, In the event of a significant medication-related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare. Promptly notify the provider of any significant error or adverse consequence. Implement the provider orders and monitor the resident for 24 to72 hours or as directed, communicate the event to the oncoming shift as needed to alert staff of the need for continued monitoring. Document the following information in an incident report and in the resident's clinical record: resident's name and age, medication route, dose, date and time of administration, factual description of the error or adverse consequence, name of provider and time notified, provider's order, treatment therapy or interventions, resident's condition for 24 to72 hours or as directed. III. Resident #51 A. Resident status Resident #51, age less than 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included anoxic brain damage, heroin overdose and major depressive disorder. The 3/15/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent with eating, toileting, personal hygiene, bed mobility and transfers. B. Resident interview Resident #51 was interviewed on 4/9/24 at 9:21 a.m. Resident #51 said registered nurse (RN) #1 gave her the wrong medications a couple of weeks prior. She said RN #1 told her she had received the wrong medications from another resident and started monitoring her vital signs after it happened. She said after receiving the wrong medications she had a bad headache and urinated all day. She said she later told the assistant director of nursing (ADON) about it and the ADON wrote the information down. C. Record review Review of the other resident's (Resident #20) March 2024 medication administration record (MAR) revealed the following medications were signed off as administered (but wrongly administered to Resident #51) on 3/17/24 at 8:00 a.m. by RN #1: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Lodge Health and Rehabilitation Center	1637 29th Avenue Pl Greeley, CO 80634

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Allopurinol (uric acid reducer) 100 milligrams (mg); -Amlodipine 5 mg two tablets (for hypertension); -Aspirin 81 mg (for prevention of stroke); -Atorvastatin (blood lipid reducer) 10 mg; -Ferrous Sulfate 325 mg (for anemia); -Finasteride 5 mg (for enlarged prostate); -Lasix 20 mg (diuretic); -Vitamin C 500 mg; -Carvedilol 12.5 mg (for hypertension); and, -Sodium Bicarbonate 650 mg. The 3/17/24 medication and treatment administration record (MAR/TAR) revealed documentation to assess the resident's pulse rate and notify the provider if a heart rate was less than 65 beats per minute (bpm) every two hours until 3/17/24 at 4:00 p.m. The physician's order was initiated on 3/17/24 at 9:50 a.m. It was documented as checked on 3/17/24 at 10:00 a.m., 12:00 p.m. and 2:00 p.m. -The 3/17/24 MAR/TAR failed to reveal documentation of what the pulse rate was at those times and if the provider was notified. -It failed to reveal documentation if any other vital signs, including blood pressure, were monitored. The 3/18/24 MAR/TAR revealed documentation to assess heart rate and to notify provider if a heart rate was less than 65 bpm every four hours until 3/18/24 at 8:10 p.m. It was documented as checked on 3/18/24 at 12:00 a.m., 4:00 a.m., 8:00 a.m.,12:00 p.m., 4:00 p.m. and 8:00 p.m. -The 3/18/24 MAR/TAR failed to reveal documentation of what the pulse rate was at those times and if the provider was notified. -It failed to reveal documentation if other vital signs, including blood pressure, were monitored. The 3/18/24 nurse practitioner (NP) progress notes revealed the resident had received multiple medications that were prescribed for another resident. The resident reported no adverse effects and denied cardiopulmonary, gastrointestinal or genitourinary distress. -A comprehensive review of nursing progress notes failed to reveal documentation of a medication error, notification of a provider, rationale for the additional vital sign monitoring or documentation of any additional monitoring conducted. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A comprehensive review of the March 2024 CPO failed to reveal a physician's order in the CPO on vital sign monitoring and parameters and any other monitoring required after the administration of multiple wrong medications. A 3/28/24 grievance investigation revealed Resident #51's representative had been informed by Resident #51 that she had received the wrong medications. The investigation revealed the ADON followed up with RN #1 and RN #1 denied any issues. -A review of the electronic medical record (EMAR) failed to provide evidence of a medication error. A one-to-one education was provided to RN #1 regarding policy and procedure. The 3/28/24 grievance investigation revealed documentation of an employee one-to-one education provided to RN #1 on 4/9/24 on medication administration and adverse consequences with medication error policy and procedure. The education was signed by RN #1 and the ADON on 4/9/24. -The grievance investigation failed to: -Identify the frequent vital sign monitoring on 3/17/24 and 3/18/24; -Identify the lack of documentation for the frequent vital sign monitoring; -Identify the provider documentation of a multiple medications error on 3/18/24; and, -Follow up with one-to-one education provided to RN #1 until 4/9/24, twelve days after the initial grievance was initiated and 23 days after the multiple medication errors occurred. -A comprehensive review of the April 2024 CPO failed to reveal interdisciplinary team notes (IDT) notes regarding the multiple medications error or a root cause analysis. -It failed to reveal a medication error change of condition documentation. D. Staff interviews The ADON was interviewed on 4/10/24 at 12:55 p.m. The ADON said she became aware of a potential medication error during a care conference on 3/28/24 with Resident #51, the resident's representative and the social service assistant (SSA). She said Resident #51's representative said Resident #51 had told her that she had received the wrong medications from another resident. The ADON said she assessed Resident #51 and she was at baseline. She said a grievance report was initiated and she was assigned to do the follow up. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON said she reviewed Resident #51's EMR and could not find evidence of a medication error. She said she interviewed RN #1 and she had no recollection of a medication error occurring. She said she was not aware of the frequent pulse check documentation in the MAR/TAR on 3/17/24 and 3/18/24. The ADON said she did a formal one-to-one education on medication administration and adverse consequences after a medication error with RN #1 on 4/9/24. She said the investigation conducted for the grievance was an informal internal investigation. She said there was a potential that a mediation error could have happened. She said if a medication error or errors occurred, a formal investigation should be done and reported to the State Agency. She said there was no review of the medication errors by the IDT risk management and no root cause analysis conducted. The DON was interviewed on 4/10/24 at 12:55 p.m. The DON said she was new to the facility and the former DON had resigned on 3/29/24. She said all nursing staff, including agency staff, should follow the five rights of medication administration. She said nurses should prepare each medication by following the orders from the EMR and matching the order to the resident's medication card. The DON said before administering any medications, nursing staff should verbally confirm with the resident, confirm with the door name tag and confirm with the picture on the MAR in the EMR. She said, if a medication error did occur, there was a policy resource in a book at the nurses station. She said the process after a medication error was to assess the individual, contact the DON, the provider and the resident's representative. She said the physician's orders for monitoring and follow up provided by the provider should be followed. The DON said a change in condition and the risk management tool located in the EMR had a step by step process on the process that needed to be followed for a medication error. She said when a multiple medication error was identified there should be a root cause analysis done to ensure further medication errors were prevented. She said, upon review of the documentation of the frequent vital sign monitoring on the TAR for 3/17/24 and 3/18/24, something had occurred and required further follow up with the nurse involved. RN #1 was interviewed on 4/10/24 at 2:17 p.m. RN #1 said she did not recall the incident and did not recall a medication error. She said if she had made a medication error she said she would have notified the provider and done additional monitoring of the resident. She said she needed to check her notes from 3/17/24. RN #1 was interviewed again on 4/10/24 at 3:15 p.m. RN #1 said she was an agency nurse who had not worked at the facility very long. She said the facility was very busy on 3/17/24. She said she could not remember how it happened, but she said she did give Resident #51 multiple wrong medications belonging to Resident #20 during the morning medication pass of 3/17/24. She said before giving a resident a medication, the resident's identity needed to be verified verbally or if the resident was not verbal, to verify with the resident's picture in the EMR. RN #1 said after she identified the multiple wrong medications she notified the nurse practitioner at the primary care provider's office. She said she reviewed the wrong medications given with the provider. She said she had been given an order to monitor blood pressure and pulse every four hours. She said she did notify the former DON. She said she did not notify Resident #51's representative but she said she had failed to put in a progress note and put in an incident report because she did not know the facility's process. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed again on 4/10/24 at 4:00 p.m. The DON said the follow up for the multiple medications errors included reviewing with all agency nursing staff the policies on medication administration policy and on adverse consequences and medication errors. She said she would review this with current agency staff and any new incoming staff. 48113 I. Resident #70 status Resident #70, under the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included bilateral osteoarthritis resulting from hip dysplasia, depression, anxiety disorder and other chronic pain. According to the minimum data set (MDS) dated [DATE] the resident had intact cognition with a brief interview for mental status (BIMS) score of 14 out of 15. The resident did not have any rejection of care behaviors and was independent with bed mobility, transfers, locomotion, dressing, toilet use and hygiene. II. Record review The April 2024 CPO documented a physician 's order for the following pain medication: Oxycodone hydrochloride (HCl) tablet 5 mg (milligrams). Give one tablet by mouth every six hours for pain, ordered 12/12/23. The medication administration report revealed the oxycodone was to be given at 1:00 a.m., 7:00 a.m., 1:00 p. m. and 7:00 p.m. The medication administration audit report provided by the director of nursing (DON) on 4/11/24 at 9:26 a.m. for the month of March 2024 through April 2024 revealed oxycodone hydrochloride (HCl) Oral Tablet 5 MG give one tablet by mouth every six hours for pain was administered late or early (see below) on a daily basis and not according to the physician 's order. The medication administration history report documented the following for the resident 's oxycodone administrations between 3/30/24 and 4/1/24: 3/30/24: 7:00 a.m. dose The MAR entry read the medication was administered at 12:10 p.m. (four hours and 10 minutes late from the scheduled time and 10 hours and 42 minutes from the previous administered dose.) 1:00 p.m. dose The MAR entry read the medication was administered at 2:32 p.m. (32 minutes late from the scheduled time and two hours and 32 minutes from the previous administered dose, which was too early.) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7:00 p.m. dose The MAR entry read the medication was administered at 8:51 p.m. (51 minutes late from scheduled time and six hours and 19 minutes from the previous administered dose.) 3/31/24: 1:00 a.m. dose The MAR entry read the medication was administered at 12:55 a.m. (four hours and four minutes from the previous administered dose, which was too early) 7:00 a.m. dose The MAR entry read the medication was administered at 12:07 p.m. (four hours and seven minutes late from the scheduled time and 10 hours and 12 minutes from the previous administered dose.) 1:00 p.m. dose The MAR entry read the medication was administered at 5:45 p.m. (three hours and 45 minutes late from the scheduled time and six hours and 22 minutes from the previous administered dose.) 7:00 p.m. dose The MAR entry read the medication was administered at 6:57 p.m. (one hour and eight minutes from the previous administered dose, which was too early.) 4/1/24: 1:00 a.m. dose The MAR entry read the medication was administered at 2:08 a.m. (eight minutes late from the scheduled time and seven hours and 45 minutes from the previous administered dose, which was too early.) 7:00 a.m. dose The MAR entry read the medication was administered at 8:00 a.m. (five hours and 52 minutes from the previous administered dose, which was too early.) 1:00 p.m. dose The MAR entry read the medication was administered at 1:14 p.m. (six hours and 46 minutes from the previous administered dose.) 7:00 p.m. dose The MAR entry read the medication was administered at 8:05 p.m. (5 minutes late from the scheduled time and six hours and 48 minutes from the previous administered dose.) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The medication administration history report for the month of March 2024 followed the same inconsistent medication administration pattern of incorrect time administration for the resident 's oxycodone as seen above. -The facility was unable to provide incident reports for the medication errors for the time period between March 2024 through April 2024. -The facility was unable to provide progress notes to demonstrate the physician was notified of the early or late medication administrations. III. Interviews Licensed practical nurse (LPN) #1 was interviewed on 4/11/24 at 9:51 a.m. The LPN said medications that were scheduled should be administered timely which could be an hour before the scheduled time or an hour after. She said if a medication administration was administered earlier than the 1 hour before or after the scheduled time that would be a wrong time medication error. She said the electronic medical record alerted nurses only when administering medications too late but not too early and any nursing care staff that received the alert should notify the physician prior to administration. Nursing care staff should not clear the alert message and administer the medication since that would create a medication error. LPN #1 said nursing care staff should view the previous administration time prior to providing the medication to ensure six hours elapsed from the last dose in order to prevent any side effects, such as respiratory depression, if the medication was given too early. LPN #1 said she had previously administered the resident 's medications without reviewing the prior administration but she should have checked. She said she had cleared alert for administering medications too late but she did not file an incident report or notify the physician. She said moving forward she would ensure she reviewed the previous medication administration time and notified the physician if the medication was too early or if it was too late, in order to see if the physician had further orders. The director of nursing (DON) was interviewed on 4/11/24 at 4:25 p.m. The DON said a nurse should always administer medications according to the physician 's order to prevent medication errors. She said it was important to prevent errors due to the potential negative impact that pain medications might have if they were administered too late, such as the resident may exhibit pain which would negatively impact the resident 's quality of life. She said if the medications were given too early then it could lead to potential respiratory depression and even death. The DON said a nurse should review the previous administration time of a medication if scheduled to determine if the medication would be given too early and/or if the medication was going to be late. She said if the medication was outside of the physician's orders parameters, a nurse should call the physician and await new orders. She said if a nurse were to receive an alert for the medication being administered late, the nurse should stop and call the physician and await new orders and document the conversation in a nursing progress note. She said if a nurse were to ignore the message in the electronic medical record and administer the medications, the nurse should file an incident report due to administering the medication at the wrong time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she had only been at the facility for a couple of weeks and was not aware of the issue with Resident #70 's medications being administered too late or too early. She said she was not sure why the medications were being administered late or early. The DON said she needed to provide training and education to all nurses related to medication administration and incident reporting procedures for the facility to prevent wrong administration time medication errors. The nursing home administrator (NHA) was interviewed on 4/11/24 at 4:45 p.m. The NHA said a nurse should always follow the physician 's orders for medication administration and, if a nurse made an error when administering a medication, the nurse should file an incident report. The NHA said a nurse should not override the alert and administer the medications without calling the physician first. The NHA said the facility would need to provide education and training to nursing staff related to medication administration to prevent errors and to ensure if errors were identified that an incident report was filed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection in one out of two units. Specifically, the facility failed to: -Ensure resident rooms were cleaned in a sanitary manner; -Ensure manufacturer recommended surface contact times were followed for effective disinfection; -Ensure nebulizers (an apparatus that allows medications to be inhaled) were stored and cleaned according to professional standards of practice. Findings include: I. Housekeeping A. Professional reference The Centers for Disease Control (CDC) Environment Cleaning Procedures, (5/4/23), retrieved on 4/17/24 from https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#anchor/1505929362118 included the following recommendations, documented in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Proceed from high to low to prevent dirt and microorganisms from dripping or falling and contaminating already cleaned areas. The identification of high touch surfaces and items in each patient care is a necessary prerequisite to the development of cleaning procedures. Common high touch surfaces include: bed rails, IV poles, sink handles, bedside tables, counters where medications and supplies are prepared, edges of privacy curtains, patient monitoring equipment, transport equipment, call bells, doorknobs and light switches. The CDC Best Practices for Environmental Cleaning in Healthcare Facilities, last reviewed in 2023, retrieved on 4/17/24 from https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf included the following recommendations, If manufacturer's instructions are not available, use this general process to manually reprocess reusable supplies, equipment and personal protective equipment (PPE): 1. Immerse in detergent solution and use mechanical action (scrubbing) to remove soil, 2. Disinfect by fully immersing items in boiling water or fully immersing the items in disinfectant solution for the required contact time and rinsing with clean water to remove residue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Manufacturer's recommendations According to the Ecolab Peroxide Multi Surface Cleaner and Disinfectant manufacturer guidelines, last updated in 2023, retrieved on 4/17/24 from https://www.ecolab.com/offerings/all-purpose-cleaning/rapid-multi-surface-disinfectant-cleaner included the following recommendations, This EPA (Environmental Protection Agency) registered product disinfects in three to five minutes with hospital disinfection claims. C. Observations 1. Housekeeper (HSK) #1 cleaned room [ROOM NUMBER] on 4/11/24 at 11:40 a.m. HSK #1 performed hand hygiene and put on gloves. She obtained a wet washcloth out of disinfectant solution and wiped the top of the bedside table. The surface did not remain wet for three minutes. She then disposed of the washcloth into the used linen receptacle on the housekeeper cart. -HSK #1 failed to ensure the surface of the bedside table remained wet for the three minute surface disinfectant time. HSK #1 performed hand hygiene and put on new gloves. She obtained a wet washcloth out of the disinfectant solution and wiped off the top of the sink and the vanity counter. She disposed of the washcloth into the linen receptacle on the housekeeper cart. -The surface of the sink and vanity was not visibly wet for the three minute surface disinfectant time. HSK #1 performed hand hygiene and put on new gloves. She obtained the toilet brush that was in a toilet brush holder from the housekeeping cart and cleaned the inside of the toilet bowl before returning the toilet brush to the toilet brush holder and placing it into a separate compartment in the housekeeping cart. -The toilet brush was not sanitized after it was used and HSK #1 did not use a chemical to sanitize the toilet. -HSK #1 failed to spray disinfectant cleaner into the toilet bowl prior to cleaning inside the toilet bowl. HSK #1 performed hand hygiene and put on new gloves. She got a new washcloth out of the disinfectant solution. She wiped down the top of the toilet seat and then wiped underneath the toilet seat. She then wiped the top of the toilet bowl and continued with the same washcloth back up to the toilet seat. -The surface of the toilet did not remain visibly wet for the three minute surface disinfectant time. -HSK #1 failed to change gloves, perform hand hygiene and dispose of washcloth after wiping a dirty area and before wiping a clean area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HSK #1 performed hand hygiene and put on new gloves before wiping the vanity mirror. HSK #1 said she was finished cleaning the room and moved to the next room to clean. -HSK #1 failed to wipe the high touch surface areas in the room, including the call light, bed controls and door handles. D. Staff interviews HSK #1 was interviewed on 4/11/24 at 12:00 p.m. HSK #1 said the facility used Ecolab Multi Surface Disinfectant Cleaner to clean the surfaces in the rooms, including the bathroom. She said the chemical required a three minute disinfection time. She said once she wiped surfaces with the towel that was soaked in the chemical, the surface area could not be wiped off for three minutes. She said she did not know the surface had to be visibly wet for at least three minutes. HSK #1 said areas of the resident's room and bathroom needed to be cleaned from a high area to a low area. She said high touch surfaces should also be cleaned. She said she did not disinfect the toilet brush after use but returned it to its designated receptacle in the housekeeping cart. The housekeeping supervisor (HSKS) was interviewed on 4/11/24 at 12:00 p.m. The HSKS said surfaces should be cleaned from high reach to low reach areas and surfaces that had already been cleaned should not be wiped with a rag that had cleaned a dirty surface. She said high touch areas, such as door knobs and call lights, should be cleaned during the room cleaning process. The HSKS said surfaces needed to remain wet with the Ecolab Multi Surface Disinfectant Cleaner for the full three minutes to properly disinfect the surface. She said the toilet brush was not routinely cleaned after every resident room. 43950 II. Failure to ensure proper infection control practices were followed for resident-care items and equipment A. Facility policy and procedure The Cleaning and Disinfection of Resident-Care Items and Equipment policy, revised September 2022, was provided by the quality mentor (QM) on 4/9/24 at 8:15 p.m. It read in pertinent part, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (center of disease control) recommendations for disinfection and the OSHA (occupational safety and health administration) pathogens standard. B. Observations Resident #7 was observed in her room on 4/8/24 at 12:46 p.m. The resident's nebulizer unit, including mouthpiece, T-piece, and tubing was on the bed. The mouthpiece and T-piece were a carmel color. -The nebulizer mouthpiece was touching the bed surface and was not stored in a sanitary manner. (continued on next page)

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Westlake Lodge Health and Rehabilitation Center	1637 29th Avenue Pl Greeley, CO 80634

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 was observed in her room on 4/9/24 at 12:08 p.m. The resident's nebulizer unit including mouthpiece, T-piece, and tubing was on the floor, by the oxygen unit, and partially under the bed. -The unit and mouthpiece were dusty and carmel colored. -The nebulizer was on the ground with the mouthpiece on top of it. The nebulizer and mouthpiece were not stored in a sanitary manner. C. Record Review Review of the April 2024 computerized physician orders (CPO) revealed Resident #7 had an active order for nebulizer treatments and utilized the nebulizer two times per day. D. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 4/9/24 at 12:10 p.m. LPN #2 said she knew nebulizer treatments were used to inhale medication into the lungs. LPN #2 said when a nebulizer unit was not in use it was stored in the nurses cart. LPN #2 said sometimes the nebulizers are stored in the residents room on a bedside stand so that it's more easily accessible. LPN #2 viewed Resident #7's nebulizer unit on the floor and said it would not be okay to store the nebulizer on the floor because it was used to aerosol directly into the lungs and could cause dust to contaminate the resident's lungs. The director of nursing (DON) and infection preventionist (IP) were interviewed on 4/9/24 at 12:20 p.m. The DON said the unit should be stored on a table, in a bag. The DON and IP viewed Resident #7's nebulizer unit stored on the floor including the mouthpiece, T-piece, and tubing and said it should not be on the floor. The IP and DON said it was an infection control problem. The DON said she would start nursing education regarding proper storage of nebulizer equipment immediately.