STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065219	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadview Health and Rehabilitation Center	850 27th Ave 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 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** 37166 Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (#1) of three residents reviewed for quality of care out of eight sample residents. Specifically the facility failed to: -Assess and monitor Resident#1 after she developed eye drainage; and, -Ensure the facility's physician was aware Resident #1 had been diagnosed with clogged eye ducts and prescribed antibiotics for the condition by an outside provider. Findings include: I. Facility policy and procedure The Notification of Changes policy and procedure, dated 9/1/24, was provided by the nursing home administrator (NHA) on 12/18/24 at 4:30 p.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 policy did not include any pertinent information regarding documentation and assessment that must be completed upon a change of resident's condition. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included osteoarthritis, rheumatoid arthritis and diabetes. The 7/28/24 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. The resident required maximum assistance with activities of daily living (ADL). (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review The June 2024 medication administration record (MAR) revealed Resident #1 had the following physician's orders related to her eyes: Latanoprost Ophthalmic Emulsion 0.005% (percent). Instill one drop in both eyes at bedtime related to glaucoma, ordered 2/29/24. Tobrex Ophthalmic Solution (an antibiotic medication) 0.3%. Instill one drop in right eye three times a day for clogged duct for seven days, ordered 6/26/24. Warm compress to right eye four times a day for clogged duct, ordered 6/26/24 and discontinued 7/15/24. The progress note, dated 6/27/24 and written by the director of nursing (DON), documented that Resident #1 was taken out of the facility by her daughter the day before (6/26/24). Upon return to the facility, the daughter informed a nurse that the resident was prescribed an antibiotic for an eye infection by a physician from the walk-in clinic. She expressed concern that her mother had matted right eye drainage and the facility did not take any actions to address it. Another progress note dated 6/27/24 documented that the walk-in clinic's physician's order for antibiotic eyedrops was entered into Resident #1's electronic medical record (EMR) and the eye drops were administered to the resident. The progress note dated 6/29/24 documented that Resident #1 continued to receive eye drops to the right eye. The resident's eye was looking better and had less drainage noticed on the day shift. -Review of Resident #1's EMR revealed there was no documentation to indicate that the resident's right eye was assessed by nursing staff for drainage before 6/27/24. -Review of Resident #1's EMR revealed there was no documentation on 6/27/24 to indicate that the resident's right eye was assessed by nursing staff or the facility's physician after the resident's return from the walk-in clinic. -Further review of Resident #1's EMR revealed there was no documentation to indicate that the resident's primary physician was notified about the resident's right eye condition or that the resident had been prescribed an antibiotic eyedrop medication by an outside provider which was administered to the resident. III. Staff interviews Registered nurse (RN) #1 was interviewed on 12/18/24 at 1:30 p.m. RN #1 said she knew Resident #1 well and she remembered that the resident had an eye infection some time in the summer of 2024. She said she did not recall the details of the infection, but she did remember administering eye drops to the resident. She said drainage from the eye should be documented in the progress notes and the resident should have been assessed for a change of condition which included an assessment of the eye. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 said family and the primary care physician should be notified when a resident had a change of condition. She said all medications that family brought into the facility should be reported to the physician and orders obtained before administering the medication to the resident. RN #2 was interviewed on 12/18/24 at 2:05 p.m. RN #2 said drainage from a resident's eye was considered to be a change of condition. He said the resident should be assessed and findings documented on the change of condition form. He said daily notes should document the condition of the eye. The DON was interviewed on 12/18/24 at 3:40 p.m. The DON said any changes in a resident's condition should be documented in a change of condition form. She said when Resident #1 started to experience drainage from her eye, she should have been assessed by a nurse who should have then documented in the progress notes the condition of her eye. She said she believed Resident #1's physician was contacted to inform him of the new orders from the walk-in clinic, however, she was not able to locate the note to confirm the physician was notified. The DON said she was not able to locate any additional nursing progress notes which indicated Resident #1's right eye drainage was assessed by the facility prior to 6/27/24 when the resident went to the walk-in clinic. She said if the resident started to experience drainage in the eye it should have been documented prior to 6/27/24.

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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** 50219 Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazardous situations for two (#7 and #3) of five residents reviewed for accident hazards out of eight sample residents. Specifically, the facility failed to repair the handicap-accessible door to the smoking patio in a timely manner and ensure the door functioned properly and was safe to use while it was broken for Resident #7 and Resident #3. Findings include: I. Facility policy and procedure The Fall Management System policy, revised November 2024, was received from the nursing home administrator (NHA) on 12/18/24 at 4:07 p.m. It read in pertinent part, It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The quality assessment and assurance (QAA) committee will analyze trends related to falls and will determine if further intervention is needed. II. Resident group interview and observations A group interview was conducted on the facility's smoking patio on 12/18/24 at 10:24 a.m. with four residents (#3, #4, #5 and #6) who were identified as interviewable by the facility and assessment. Resident #3 said the handicap button on the door to the smoking area was broken for months and the door would not open automatically during that time. Resident #3 said the door started working again a few weeks ago. Resident #3 said she repeatedly complained about the door to the staff at the facility, but the staff's response was only that they were still waiting for a part to fix it. Resident #3 said her knuckles were repeatedly scratched from trying to get through the smoking area door in her wheelchair and her knuckles were only just starting to heal. Resident #3 had multiple scabs along her knuckles that were in different stages of healing. Resident #3 and Resident #5 said Resident #7 fell out of his wheelchair because the door to the smoking patio was not opening automatically and had to be physically opened. Resident #3 and Resident #5 said that Resident #7 was not injured from the fall. Resident #4 and Resident #5 said they both had a difficult time getting in and out of the smoking area door in their wheelchairs when it was broken. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 said he had a difficult time getting into and out of the smoking area when the door was broken a few weeks prior. At 10:40 a.m. Resident #4 tried to leave the smoking area and re-enter the building. The handicap door repeatedly tried to close on the resident's wheelchair while Resident #4 was trying to navigate his wheelchair over the threshold of the door, despite the handicap button being pressed. Resident #3 said she needed to help Resident #4. Resident #3 proceeded to hold the door for Resident #4 as he grabbed both sides of the door frame so he could leverage his wheelchair up and over the door's threshold. III. Resident #7 A. Resident status Resident #7, age 77, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included arthritis, repeated falls, generalized muscle weakness and alcoholic polyneuropathy (a neurological disorder that occurs when peripheral nerves throughout the body malfunction simultaneously). The 9/17/24 minimum data assessment (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was dependent for most activities of daily living (ADL). B. Resident interview Resident #7 was interviewed on 12/18/24 at 2:05 p.m. Resident #7 said the door to the smoking area was broken for two weeks a while back. Resident #7 said he fell out of his wheelchair during the time the door was broken because he was trying to get in from the smoking area and could not get over the ledge of the threshold while trying to hold the door open himself. Resident #7 said he was not hurt during the fall. C. Record review A progress note, dated 10/23/24 at 10:20 p.m., revealed Resident #7 had a witnessed fall when coming in from the smoking patio. Resident #7 tried to open the door but found it too heavy. Resident #7 was helped back into his wheelchair by the nursing staff using a Hoyer lift. A progress note, dated 10/24/24 at 10:36 a.m., revealed the facility's interdisciplinary team (IDT) performed a fall review of Resident #7's 12/23/24 fall. The IDT team implemented an intervention to place a sign on the smoking patio door and educated Resident #7 on asking for assistance when going in and out of the smoking patio door. -However, the IDT note did not indicate that the handicap button on the smoking patio door was broken or identify when the door would be fixed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The fall committee IDT note, dated 10/24/24 at 10:39 a.m. revealed Resident #7 had a witnessed fall on 10/23/24 at 6:45 p.m. in the entryway of the smoking patio. Predisposing factors included that Resident #7 had been outside smoking and the handicap button to the door was not working properly. Resident #7 was attempting to come in from the smoking patio and was not able to manage the door by himself. The door hit the back of Resident #7's wheelchair and he slid out from his chair. Interventions included placing a sign on the smoking patio door asking residents to ask for assistance when going out or coming in from the smoking area until the door was repaired. -The note did not identify what the facility was doing to fix the door or identify where the facility was in the process of getting the door fixed. A progress note, dated 12/16/24 at 5:07 p.m., revealed Resident #7 had an unwitnessed fall. The nurse writing the note found Resident #7 lying on his back on the threshold to the smoking patio and did not see any signs of injury. The fall committee IDT note, dated 12/17/24 at 9:11 a.m., revealed Resident #7 had an unwitnessed fall on 12/16/24 at 4:42 p.m. coming back in from the smoking patio. Predisposing factors for Resident #7 included weakness and having a hard time getting back in from the smoking patio over the threshold. Resident #7 was coming into the facility from the smoking patio and having difficulty getting over the threshold of the door and fell out of his wheelchair. Interventions included having Resident #7 continue to work with therapy. -The note did not identify that the facility had assessed the threshold of the smoking patio door to identify if there were potential hazards with the threshold which could contribute to other potential falls for residents. IV. Resident #3 A. Resident status Resident #3, age 82, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included congestive heart failure, chronic respiratory failure, history of falling and generalized muscle weakness. The 10/8/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. B. Record review Wound assessment notes, dated 10/31/24, revealed Resident #3 had blisters to her left great toe, left medial ankle, left lateral ankle and left great toe, and abrasions to her left anterior knee, left anterior shin, and left proximal anterior shin. The abrasion to the left proximal anterior shin was acquired on 10/23/24 and the others were at least one month old at the time of assessment. The wound assessment notes revealed Resident #3 reported to the physician that she was having to use her left knee and left foot to open the door to the smoking patio because the door did not automatically open. The physician discussed with Resident #3 that she should have a staff member help her open the door to prevent further injury to her left knee and left toes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The wound assessment notes did not reveal any abrasions identified on Resident #3's hands. Review of weekly skin assessments from 9/20/24 through 12/18/24 did not reveal any abrasions on Resident #3's hands. -However, Resident #3 had multiple scabs on her knuckles (see observation above). V. Staff interviews Hospitality aide (HA) #1 was interviewed on 12/18/24 at 2:18 p.m. HA #1 said she knew there was an issue with the smoking patio door a few weeks ago but that it was fixed now. HA #1 said the handicap button for the door was not working and the door was not closing all the way. Certified nurse aide (CNA) #1 was interviewed on 12/18/24 at 2:21 p.m. CNA #1 said she knew the smoking patio door was broken but it got fixed quickly. CNA #1 said she had not heard about any issues with the handicap button. -However, the handicap button on the smoking patio door was broken from 9/22/24 until 11/20/24 (see additional record review below). Licensed practical nurse (LPN) #1 was interviewed on 12/18/24 at 3:07 p.m. LPN #1 said Resident #7 fell on [DATE] at around 5:00 p.m. LPN #1 said Resident #7 fell at the threshold of the door to the smoking area. LPN #1 said Resident #7 was able to use his wheelchair to get to the door but could not push the door open. LPN #1 said the door to the smoking area was too heavy for wheelchair users to push open, but they could push the handicap button to open the door. LPN #1 said she had not heard of any issues with the handicap door mechanism. The maintenance supervisor (MS) was interviewed on 12/18/24 at 3:20 p.m. The MS said there was something wrong with the internal mechanisms of the motor for the smoking patio door so that the motor was not communicating with the handicap buttons inside and outside the door. He said the issue began in September 2024. The MS said the parts for the motor were on backorder so the vendor had to replace the whole motor. The MS said the issue with the smoking patio door was noticed on 9/24/24 and the door was repaired by the vendor on 11/20/24. The MS said the facility advised the residents to open the door to the smoking patio with caution while the handicap door motor was broken, as the door had some kickback to it. The director of nursing (DON) and the NHA were interviewed together on 12/18/24 at 3:42 p.m. The NHA said the handicap button on the smoking patio door stopped working but could not recall the date. The NHA said the vendor came out to repair it but did not have the proper parts. The NHA said the delay in getting the door repaired stemmed from having to get quotes to replace the whole handicap button. The NHA said, in the meantime, the staff in that section of the facility were there to help the residents open the door to the smoking area. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation to indicate if the facility attempted to identify another vendor who could fix the door in a more timely manner when the initial vendor canceled the replacement of the door on two separate occasions. Additionally, a grievance form from Resident #7's representative, dated 11/13/24, revealed Resident #7's representative expressed frustration about the handicap accessibility button being broken for the smoking patio door. The response was that the NHA explained to the representative that the vendor would be out that week to perform the required maintenance to repair the door. -However, the smoking patio door was broken for almost two months before it was fixed.