STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065229	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Post Acute and Rehabilitation Center	2701 California St Pueblo, CO 81004

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52309 Based on record review and interviews the facility failed to develop and implement a baseline care plan that included the instructions needed to provide effective and person-centered care for three (#3, #11 and #14) of four residents reviewed for baseline care plans out of 22 sample residents. Specifically, the facility failed to ensure pertinent medical information was included on Resident #3, Resident #11 and Resident #14's baseline care plans within 48 hours of admission. Findings include: I. Facility policy and procedure The Comprehensive Person-Centered Care Planning, revised January 2022, was received from the nursing home administrator (NHA) on 2/26/25 at 5:08 p.m. It read in pertinent part, The interdisciplinary team (IDT) will develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. The baseline care plan will include minimum healthcare information necessary to properly care for a resident including, but not limited to: physician orders, dietary orders, social services and PASRR recommendations. II. Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included encephalopathy (brain disorder), schizoaffective disorder bipolar type (mental illness that causes unusual shifts in a person's mood and behavior), borderline personality disorder and violent behavior. The 1/9/25 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. B. Record review (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0655

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of Resident #3's electronic medical record (EMR) revealed the resident was admitted with a pre-admission screening and resident review (PASRR) Level II evaluation, dated 12/17/24. The PASRR Level II findings revealed the resident had diagnoses of schizophrenia and bipolar I disorder with psychotic features. Pertinent information included Resident #3 experienced auditory and visual hallucinations, impulsive behavior, irrational thought content with aggressive behavior (yelling, cussing, throwing medication and food) in the hospital and at her previous assisted living facility (ALF). Specialized services required included psychiatry case consultation, case management, behavior management/therapy and neurocognitive evaluation.

-Review of the baseline care plan, dated 12/27/24, did not include the level II PASRR findings or the specialized services that were required.

III. Resident #11

A. Resident status

Resident #11, age less than 65, was admitted [DATE]. According to the February 2025 CPO, diagnoses included metabolic encephalopathy, end stage renal failure, major depressive disorder and generalized anxiety.

The 1/7/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15.

B. Record review

The discharging hospital's transition report, dated 1/31/25, revealed the resident was on a

end-stage renal diet and was receiving hemodialysis (medical procedure that filters waste out of the blood). The report indicated to limit the resident's sodium, potassium and phosphorus intake.It also indicated the resident was on a 1200 milliliter (mL) daily fluid restriction, and

was receiving oxygen 3 liters per minute (LPM) by nasal cannula.

Review of Resident #11's EMR revealed the resident was admitted with a PASRR Level II evaluation, dated 1/29/25. The PASRR indicated the resident had diagnoses of major depressive disorder, unspecified bipolar and generalized anxiety disorder. The recommendations included, in pertinent parts, psychiatric consultations to evaluate her medications and to rule out bipolar diagnosis and continued individual therapy. Specialized services required included psychiatry case consultation and individual therapy.

-Review of the baseline care plan, dated 2/1/25, did not specify the resident was prescribed an end-stage renal diet, fluid restriction, or oxygen. The baseline care plan did not indicate the resident was receiving hemodialysis and did not include PASRR findings or requirements.

IV. Resident #14

A. Resident status

(continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #14, age 88, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 CPO, the diagnoses included sepsis (infection of the blood), type 2 diabetes, depression and generalized anxiety. The 1/28/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. B. Record review The discharging hospital's transition report, dated 1/27/25, revealed in pertinent part, that the resident was prescribed a diabetic diet and oxygen at 2 LPM by nasal cannula. The report indicated the resident had diagnoses of depression and generalized anxiety disorder. -Review of the baseline care plan, dated 1/27/25, did not include the resident's need for a diabetic diet, or the resident's oxygen use. V. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 2/26/25 at 2:35 p.m. LPN #1 said when a new resident was admitted to the facility, the staff looked through the admission paperwork, CPOs and miscellaneous information to find the information on how to care for the resident. She said the admitting nurse initiated the baseline care plan. The NHA, the director of nursing (DON) and the social services corporate consultant (SSCC) were interviewed together on 2/26/25 at 4:40 p.m. The DON stated the baseline care plan needed to be completed within 48 hours of admission with the pertinent information to be able to provide appropriate care. The DON said the admitting nurse initiated the baseline care plan. The DON and the SSCC said the baseline care plans needed to include specific information such as diet specifications and PASRR information.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52288 Based on observations, record review and staff interviews, the facility failed to provide an ongoing program to support residents in their choice activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for three (#10, #6, and #4) of three residents reviewed for activities programming out of 22 sample residents. Specifically, the facility failed to offer and provide personalized activity programs for Resident #10, #6 and #4. Findings include: I. Activity calendar The February 2025 activity calendar for the week of 2/23/25 through 2/28/25 revealed there were seven to eight activities scheduled per day. The activity calendar had mind-stimulating activities scheduled on four of seven days for the week (2/23/25, 2/24/25, 2/25/25 and 2/26/25) in the form of Bingo. There was only one activity scheduled for the week for non-social dementia residents in the form of Puppy Friday (2/28/25). II. Resident #10 A. Resident status Resident #10, age 78, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and dementia. The 2/14/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments. Per staff assessment, the resident had both short-term and long-term memory problems, the resident's cognitive skills for daily decision-making were severely impaired and the resident exhibited inattention. The resident required extensive assistance from one staff member for activities of daily living (ADL). The 9/16/24 MDS assessment revealed it was very important for the resident to be around animals, music, keep up on the news, attend religious services and go outside for fresh air. B. Observations During a continuous observation of the resident in the activities room on 2/25/25, beginning at 10:45 a.m. and ending at 11:44 a.m., the following was observed: At 10:45 a.m. the resident was sitting in her wheelchair but was not participating in the arts and crafts activity. The activity staff did not engage with her or encourage her to take part in any activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:09 a.m. the activity director (AD) asked Resident #10 if she wanted hot cocoa. At 11:10 a.m. the AD moved the resident to a nearby table. At 11:13 a.m. the AD brought Resident #10 a cup of hot cocoa with a straw and asked her if she wanted to drink, as the resident required hands-on assistance. The AD held the cup and guided the straw to the resident's mouth and she took a sip. At 11:16 a.m. the AD asked the resident if she wanted her nails painted pink. However, after asking the resident the question, the AD did not paint the resident's nails. At 11:40 a.m. an unidentified staff member assisted Resident #10 from the activity room to the community room for lunch. On 2/25/25 at 1:25 p.m. Resident #10 was in the common area at the end of hallway F, watching television (TV). At 1:34 p.m. an unidentified staff member assisted the resident to the activities room where she sat idle with no participation in any activities. At 2:03 p.m. Resident #10 was again in the common area and had no meaningful activity provided. The resident was staring downward. On 2/26/25 at 10:00 a.m. residents from around the facility were gathered in the activity room for the scheduled Catholic communion service. At 10:05 a.m. Resident #10 was sitting in the common area. The TV was on, however, there were no active meaningful activities provided to the resident. -The Catholic communion service concluded at approximately 10:25 a.m. -The facility failed to ensure Resident #10, whose religion had been identified as being very important to her, was assisted to the Catholic communion service. At 10:32 a.m. the resident was assisted to the activity room by an unidentified certified nurse aide (CNA). The unidentified CNA backed Resident #10 up against the wall near the door in the activity room and left. The resident sat alone while others were at nearby tables coloring. C. Resident #10's representative interview Resident #10's representative was interviewed on 2/26/25 at 10:06 a.m. The representative said staff tended to put Resident #10 down for a nap, rather than engaging her in activities. The representative said Resident #10 enjoyed listening to music and being part of a group. The representative said when she visited the facility, she had observed Resident #10 sitting in the common area at the end of Hall F, watching TV. The representative said the facility could encourage Resident #10 to participate in more activities. D. Record review (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's activity care plan, revised on 2/6/25, identified the resident's activity preferences included enjoying snacks between meals, eating sweets such as ice cream, listening to music, especially oldies and Mexican music, animals and participating in group activities, such as community parties, music performances, movies, puppy visits, going outside for fresh air, food socials and spending time with family and friends. The care plan documented that the resident was passive and required assistance during all group activities. Pertinent interventions included all staff conversing with the resident while providing care, assisting her with ADLs as needed during activities, encouraging ongoing family involvement, inviting family to attend special events, engaging her in group activities such as food socials, music performances, and crafts, playing oldies on her Bluetooth speaker, providing an activities calendar and notifying her of any calendar changes. The February 2025 activity participation documentation received from the AD on 2/26/25 documented Resident #10 was active with the independent activity of watching TV daily. The social activity section of the participation records was also marked as TV daily from 2/11/25 to 2/26/25. The record documented the resident attended group activities less than daily. The activity participation records documented Resident #10 had not attended any of the creative activities. Further review of Resident #10's activity participation records revealed the resident was offered a one-on-one activity daily from 2/11/25 to 2/26/25 for an unknown amount of time. -The resident was documented as receiving one-on-one activity visits daily, however, the one-on-one activity visits consisted of the activity staff meeting with the resident daily to bring the daily activities calendar, pages to color and, if able, bringing the resident beads to make bracelets (see AD interview below). The activity participation record for 2/26/25 for spiritual activities such as church services, documented Resident #10 attended a spiritual activity on 2/26/25. -However, the church service was over by the time staff brought the resident to the service (see observations above). III. Resident #6 A. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included cognitive communication deficit, unspecified dementia, psychotic disturbance, and mood disturbance. The resident required step-by-step instructions as needed, a consistent routine, and structured activities to support cognitive function and maximize involvement in daily decision-making. The 12/20/24 minimum data set (MDS) assessment revealed the resident had intact cognition with a BIMS score of 15 out of 15. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/3/24 MDS assessment revealed it was very important for the resident to keep up with the news, go outside and somewhat important to have music, to be around groups of people and to do activities of choice. B. Observations On 2/25/25 at 10:05 a.m. Resident #6 was sitting in the lounge in a recliner. The TV was on but there was no meaningful activity going on in the lounge area. On 2/25/25 at 1:25 p.m. Resident #6 was transferred to her recliner in the common area at the end of hallway F and was given a cookie. On 2/25/25 at 2:22 p.m. Resident #6 was sitting in her recliner in the common area, sleeping, with the TV on. On 2/26/25 at 9:17 a.m. Resident #6 was sleeping in a recliner in the common area at the end of hallway F. On 2/26/25 at 1:22 p.m. the resident was in the common area, watching T.V. On 2/26/25 at 2:13 p.m. Resident #6 was sleeping in her recliner in the common area while other residents participated in a bingo activity. C. Resident #6's representative interview Resident #6's representative was interviewed on 2/26/25 at 10:20 a.m. The representative said Resident #6 enjoyed activities, such as bingo and cornhole. He said the facility could better accommodate her by slowing down the pace of calling numbers during bingo to make it easier for her to follow along, as her vision was not great. He said Resident #6 enjoyed activities, participating in them and being part of a group. D. Record review Review of Resident #6's activity care plan, updated 2/26/25 (during the survey), identified the resident had impaired cognitive function, thought processes, and decision-making due to dementia and outlined goals to support her lifelong interests, including family visits, phone calls, holiday parties, coffee, bingo and shopping. Interventions included providing individual activities to the resident, necessary activity supplies, daily social contact and respecting the resident's right to refuse group activities. The February 2025 participation documentation received from the AD on 2/26/25 revealed Resident #6 was active with the independent activity of watching TV daily. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 was documented as receiving one-on-one activity visits daily, however, the one-on-one activity visits consisted of the activity staff meeting with the resident daily to bring the daily activities, pages to color and, if able, bringing the resident beads to make bracelets (see AD interview below). IV. Resident #4 A. Resident status Resident #4, age 81, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included schizophrenia. The 12/23/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of zero out of 15. The resident required extensive assistance with ADLs. The 7/25/24 MDS assessment revealed it was very important for Resident #4 to do activities she liked, go outside to get fresh air and somewhat important to have books to read and listen to music. The assessment indicated it was not very important for the resident to be around animals, such as pets. B. Observations On 2/25/25, the following observations were made: At 10:00 a.m Resident #4 was sitting in the common lounge in front of the television (TV). She was not paying attention to the TV. Staff did not interact with her. At 10:30 a.m., the resident continued to sit in her wheelchair in the common area lounge. The TV continued to be on, however, Resident #4 was not watching it. At 2:00 p.m Resident #4 continued to sit in the common area lounge in front of the TV. There were no meaningful activities provided to the resident and staff did not interact with her. At 3:36 p.m. the resident was in bed and awake. There was no music playing in her room and no touch stimulation or books in her bed. At 3:57 p.m Resident #4 was sitting in the common area lounge again. There were no meaningful activities provided to the resident. On 2/26/25 at 3:30 p.m. Resident #4 was sitting in the common area lounge. The TV was on, however, the resident was not watching it. The AD asked the resident if she wanted to go to an activity and the resident said no. -The AD did not provide further encouragement to the resident to attend the activity and did not offer the resident a meaningful activity to do instead. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The AD did not offer hot chocolate or coke to the resident, which the resident enjoyed, to encourage the resident to attend the activity (see AD interview below). C. Resident representative interview Resident #4's representative was interviewed on 2/26/25 at 2:18 p.m. The representative said Resident #4's social activity levels had decreased through the years. She said the facility informed her that Resident #4 was put on a one-on-one activity program. She said she was not aware that the resident was no longer on the one-on-one activity program. She said Resident #4 liked to listen to music, however, she said she got overstimulated easily. The representative said Resident #4 liked to fidget with her hands and enjoyed the teddy bears she used to receive from staff. D. Record review Review of Resident #4's activity care plan, updated 10/4/24, revealed the resident said she only wanted to be in her room and left alone and not bothered and staff would provide independent leisure activities upon request. Pertinent interventions included providing one-on-one activities, staff would respect her right to limit or decline activities, inviting the resident to scheduled activities so she knew she was welcome to join organized group activities and activities staff would provide independent leisure activities upon request. -The care plan documented the Resident #4 would refuse to attend activities, however, there were no special instructions on how to invite the resident to activities. Review of Resident #4's electronic medical record (EMR) revealed the following progress notes related to activities: The 10/4/24 progress note documented a puppy activity was completed. -However, the 7/25/24 MDS assessment revealed it was not very important for the resident to be around animals (see resident status above). The 11/8/24 progress note revealed Resident #4 refused a one-on-one activity visit. The progress note further documented the resident liked coffee socials and music. There was no documentation of the resident enjoying music in the note. -There were no further progress notes documented in Resident #4's EMR to indicate one-on-one activity visits were offered to the resident following the resident's refusal of the one-on-one activity visit on 11/8/24. -Review of the resident's EMR did not reveal documentation to indicate Resident #4 was assisted to go outside per her preference. Review of Resident #4's EMR activity participation record for the past 30 days revealed the resident had attended one entertainment activity on 2/24/25. Independent activities were documented on the record, however, the record did not indicate what independent activities Resident #4 participated in. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Staff interviews The AD was interviewed on 2/26/25 at 3:14 p.m. The AD said she recently became the AD at the facility. She said she previously worked as an activity assistant in another building prior to her current job. The AD said she was currently working on her activity certification. She said the facility had two full-time employees, one part-time employee, and one as needed (PRN) staff member who covered activities seven days a week. The AD said the activities staff offered one-on-one activities three times a week. She said either she or another activity staff member provided the sessions, which could include nail care, listening to music, watching a movie, sitting outside, participating in Puppy Fridays or bird watching, depending on the resident's cognitive awareness. She said residents who scored between eight to 15 on the BIMS assessment could participate in group activities and did not qualify for a one-on-one program. The AD said Resident #10 participated in one-on-one activities because she was unable to communicate verbally. She said activity staff engaged her by tracking her eye movements and if the resident did not attend group activities, the resident was provided with one-on-one activities. She said Resident #10 participated in Puppy Fridays and the resident enjoyed attending Catholic church services. She said if Resident #10 did not attend those activities, she ensured that the resident received one-on-one activity engagement three times a week. The AD said Resident #6 came to the morning coffee, enjoyed holiday parties and puppy parties and participated in activities.She said the resident did not stay in one place and came and went to the activities. She said the facility had Resident #6 participate in activities and took her on daily walks around the facility. The AD said that a box with knitting and crocheting supplies, including a magnifying glass, was in the resident's room for her to use. She said Resident #6 enjoyed bingo, especially with her son. The AD said the resident did not like to participate in activities much. The AD said staff did not wake Resident #6 up to play bingo unless the resident requested it. The AD said the activities staff documented if the resident refused activities. The AD said sitting in the lounge area in front of the TV accounted for independent activity for Resident #4. She said the resident liked to drink coke and hot chocolate. She said the resident would refuse activities, but if she was offered coke or hot chocolate, she would attend. She said Resident #4 used to be on a one-on-one activity program but was taken off the program on 11/13/24 because she was refusing. The AD said she had not reattempted to provide Resident #4 with one-on-one activities since she was taken off the one-on-one activity program. The social services corporate consultant (SSCC) was interviewed on 2/26/25 at 3:40 p.m. The SSCC said all residents should be invited to attend the activities. She said she had informed the activity staff that each resident needed to be charted on each day with each activity. She said when a resident refused activities, they should be re-approached in a different way, such as offering hot chocolate to Resident #4, in order to encourage them to attend. 52094