STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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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 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** 47150 Based upon observations, interviews and record review, the facility failed to ensure one (#32) of three residents reviewed for assistance with activities of daily living (ADL) received fingernail care out of the 31 sample residents. Specifically, the facility failed to ensure Resident #32's fingernails were trimmed and clean. Findings include: I. Facility policy and procedure The Fingernails/Toenail policy, revised February 2018, was provided by the nursing home administrator (NHA) on 4/30/24 at 1:56 p.m. It revealed in pertinent part, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent residents from accidentally scratching and injuring their skin. II. Resident #32 A. Resident status Resident #32, age greater than 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included dementia, muscle weakness, and anoxic brain damage (brain injury related to lack of oxygen). The 2/6/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. He required one person physical assistance with transfers.He required extensive assistance with bed mobility, dressing, eating, toileting, and personal hygiene. B. Observations (continued on next page)

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 10:21 a.m., Resident #32 was lying in bed. Resident #32's fingernails were visibly soiled. The resident's fingernails were dirty with a dark substance underneath several nails. The resident's fingernails were untrimmed and approximately one inch long. On 4/25/24 at 1:50 p.m. the resident was sitting in his wheelchair in the 600 hall dining room watching television. The resident's fingernails were untrimmed, visibly soiled and had a dark substance under several nails. On 4/29/24 at 3:15 p.m. Resident #32 was observed in his bed in his room. His fingernails were untrimmed and were one inch long. There continued to be dark debris underneath his fingernails. On 4/30/24 at 11:14 a.m. the resident was observed with trimmed but dirty fingernails (dark debris) underneath several nails. -CNA #1 trimmed Resident #32's fingernails on 4/29/24 but did not clean the dark debris from underneath the nails. C. Record review The comprehensive care plan, revised 1/30/24, revealed the resident was at risk for skin breakdown related to anoxic brain damage, generalized weakness, decreased mobility and self inflicted scratches to arms. The interventions included encouraging the resident to allow his fingernails to be trimmed and cleaned. The 2/4/24 progress note documented the resident received fingernail care because his fingernails were long and dirty with dark debris underneath his nails. The resident tolerated it with no behaviors. -However, a review of the resident's electronic medical record (EMR) on 4/30/24, did not reveal documentation to indicate the resident had received further nail care since 2/4/24. III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 4/29/24 at 1:25 p.m. CNA #1 said Resident #32 required assistance with his activities of daily living (ADL), including trimming his fingernails. She said the resident's fingernails were long and had a dark substance underneath them. CNA #1 said dirty and long fingernails could cause injuries such as skin tears CNA #1 said she would assist the resident with fingernail care. Licensed practical nurse (LPN) #2 was interviewed on 4/29/24 at 1:40 p.m. LPN #2 said Resident #32 was dependent on staff and required total assistance with his ADLs. LPN #2 said the CNAs were responsible for providing nail care for every resident during showers and as needed. He said Resident #32's nails were dirty and long. LPN #2 said the resident was at risk of skin breakdown and self-inflicted scratches with his long fingernails. He said the resident's fingernails should be kept trimmed and cleaned. LPN #2 said dirty fingernails could collect bacteria that could lead to the resident getting sick. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 4/30/24 at 2:15 p.m. The DON said the nursing staff was responsible for ensuring residents were assisted with fingernail care. The DON said long and dirty fingernails could lead to illness and injuries, such as skin tears. The DON said she would provide education to the nursing staff and ensure staff completed weekly checks of the resident's nails to ensure their nails were kept clean and trimmed.

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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 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** 31820 Based on observations, record review and interviews, the facility failed to ensure one (#27) of five residents reviewed for unnecessary medications out of 31 sample residents received the highest practicable treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. Specifically, the facility failed to ensure a resident with a continuous glucose monitor was monitored effectively to include frequency of the glucose monitor changes, training staff on the continuous glucose monitor, and care planning the use of a continuous glucose monitor. Findings include: I. Professional reference According to the Freestyle Libre 2 continuous glucose monitor manufacturer's guidelines, retrieved on 5/1/24 from https://www.freestyle.[NAME]/us-en/safety-information.html, What should you know about wearing a Sensor: -The Sensor can be worn for up to 14 days. -Some individuals may be sensitive to the adhesive that keeps the Sensor attached to the skin. If you notice significant skin irritation around or under your Sensor, remove the Sensor and stop using the System. Contact your healthcare professional before continuing to use the System. -Intense exercise may cause your Sensor to loosen due to sweat or movement of the Sensor. Remove and replace your Sensor if it starts to loosen and follow the instructions to select an appropriate application site. -The System uses all available glucose data to give you readings so you should scan your Sensor at least once every 8 hours for the most accurate performance. Scanning less frequently may result in decreased performance. -Do not reuse Sensors. The Sensor and Sensor Applicator are designed for single use. Reuse may result in no glucose readings and infection. Not suitable for re-sterilization. Further exposure to irradiation may cause inaccurate results. -If a Sensor breaks inside your body, call your healthcare professional. According to the Freestyle Libre 2 continuous glucose monitor manufacturer's guidelines, retrieved on 5/1/24 from https://www.freestyleprovider.[NAME]/us-en/monitoring-freestyle-libre.html. Easy to monitor: FreeStyle Libre 2: Minute-to-minute glucose readings stream directly to your patients' smartphones. II. Resident #27 (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #27, age 68, was admitted on [DATE]. According to the April 2024 computerized physician's order (CPO), diagnoses included Type I diabetes mellitus, muscle weakness and chronic pain. The 3/1/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. B. Resident interview Resident #27 was interviewed on 4/24/24 at 9:50 a.m. Resident #27 said he had a continuous glucose monitor. He said he would report his blood glucose levels to the nurse three times a day when he received the blood glucose levels on his smartphone. C. Record review The care plan, initiated 12/7/23 and revised 4/26/24, identified Resident #27 had a diagnosis of diabetes. Interventions included obtaining blood glucose checks as ordered and reporting to the physician if the blood glucose was outside of set parameters. -The diabetic care plan did not address the use of a continuous glucose monitor. The April 2024 CPO documented the following physician's orders: Monitor the blood sugar via cgm (continuous glucose monitor) to the upper arm before meals every day (QD). Ordered 3/20/24. Okay to use Freestyle Libre 2 cgm (continuous glucose monitor). Ordered 3/7/24. -The April 2024 CPO did not identify the frequency of cgm (continuous glucose monitor) changes or identify that the resident was to report blood glucose levels to the nurse that he received on his smartphone. -The facility was unable to provide documentation to indicate the staff had been trained on how to use Resident #27's Freestyle Libre 2 cgm (continuous glucose monitor). II. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 4/29/24 at 10:40 a.m. LPN #2 said she had not received any training on the continuous glucose monitor. She said she thought the continuous glucose monitor would be changed every eight days. She said there was not an order that identified the day the continuous glucose monitor needed to be changed. She said Resident #27 reported his blood sugars to the nurse on duty. (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 nursing (DON) was interviewed on 4/29/24 at 4:10 p.m. The DON said Resident #27 reported his blood sugars to the nurse. She said he would get the readings on his phone. She said he changed his monitor by himself and kept his own supplies. She said the facility should have kept track of the frequency for when the continuous glucose monitor needed to be changed. She said the continuous glucose monitor was good for 14 days and she would provide education to the staff. She said the facility had just completed an assessment that identified he was able to change his monitor on his own. She said the assessment should have been done sooner. She said there should have been a care plan to identify the use of a continuous glucose monitor. She said the facility would revise the care plan and train the staff on the Freestyle Libre 2 continuous glucose monitor.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on observations, record review and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice and the comprehensive person-centered care plan for one (#20) of three residents reviewed for respiratory care out of 31 sample residents. Specifically, the facility failed to ensure Resident #20 received oxygen therapy in accordance with the physician's order. Findings include: I. Facility policy and procedure The Oxygen Administration policy, revised October 2010, was provided by the nursing home administrator (NHA) on 4/29/24 at 1:59 p.m. It revealed in pertinent part, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician' s order for this procedure. Review the physician' s orders or facility protocol for oxygen administration. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. II. Resident #20 A. Resident status Resident #20, age greater than 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included dementia, anxiety disorder, malignant neoplasm of an unspecified part of the left lung (lung cancer), chronic obstructive pulmonary disease (airflow blockage) and type two diabetes (abnormal glucose levels). The 2/13/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. She required two person physical assistance for transfers and one person physical assistance with bed mobility, dressing, eating, toileting and personal hygiene. The MDS assessment indicated the resident used oxygen therapy. B. Observations On 4/24/24 at 9:20 a.m., Resident #20 was lying in bed with oxygen in place via nasal cannula. The oxygen concentrator was set at 4 liters per minute (LPM) via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 10:50 a.m. the resident was lying in bed. There were two unidentified staff members in her room assisting her to reposition in bed. The oxygen concentrator was set at 4 LPM of oxygen via nasal cannula. On 4/29/24 at 2:15 p.m. the resident was receiving oxygen at 4 LPM via nasal cannula. On 4/30/24 at 9:14 a.m. the resident was receiving oxygen at 4 LPM via nasal cannula. C. Record review The respiratory care plan, revised 10/10/24, documented the resident required oxygen therapy related to ineffective gas exchange. The interventions included applying oxygen via nasal cannula at 3 LPM continuously and administering medications as ordered by the physician. The April 2024 CPO documented a physician's order for oxygen to be set 3 LPM via nasal cannula continuously to keep the resident's oxygen saturation at or above 90%, ordered on 12/28/24. A review of the April 2024 medication administration record (MAR) from 4/1/24 to 4/30/24 documented the licensed nursing staff documented the resident received 3 LPM of oxygen via nasal cannula. -However, observations on 4/24/24, 4/25/24, 4/29/24 and 4/30/24 revealed the resident was receiving 4 LPM. III. Interviews Certified nurse aide (CNA) #1 was interviewed on 4/29/24 at 1:20 p.m. CNA #1 said the nurses communicated the oxygen rates for each resident to the CNAs. She said the CNAs did not adjust the oxygen settings. She said the licensed nurses set the liter flow on the resident' s oxygen concentrator. CNA #1 said Resident #20's concentrator was set at 4 LPM of oxygen per nasal cannula. Licensed practical nurse (LPN) #2 was interviewed on 4/29/24 at 1:35 p.m. LPN #2 said Resident #20 was receiving 4 LPM of supplemental oxygen. LPN #2 said Resident #20 should have been receiving 3 LPM of oxygen according to the physician' s order. LPN #2 said the physician orders needed to be followed as written to ensure residents received the correct treatments and medications. LPN #2 said the physician should have been contacted to obtain a new order if there was a need to increase the resident's oxygen from 3 LPM to 4 LPM. The director of nursing (DON) was interviewed on 4/30/24 at 2:00 p.m. The DON said a physician's order was required for any medication and treatments. She said in an emergent situation, oxygen could be administered or increased, but a physician's order should be obtained within 24 hours of the change. The DON said it was the responsibility of the licensed nurses to ensure residents were on the correct liter flow of oxygen at the beginning of their shift. The DON said not following the physician' s order could result in medical complications such as shortness of breath, cell damage to the brain. She said she would provide education to the floor nurses to prevent future errors.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47150 Based on observation and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly on two of two medication carts. Specifically, the facility failed to: -Ensure insulin (medication for diabetes) pen injection devices were labeled appropriately with open dates; and, -Ensure inhaler medications were labeled appropriately with open dates. Findings include: I. Professional references According to the Lantus glargine insulin package insert, retrieved 5/6/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/021081s076lbl.pdf, When in use can be kept at room temperature for up to 28 days. According to the Humalog package insert, retrieved on 5/6/24 from https://uspl.lilly.com/humalog/humalog.html#ug, Do not use Humalog past the expiration date printed on the label or 28 days after the first usage. According to the Fluticasone inhaler manufacturer's guidelines, retrieved on 5/6/24 from https://www.advair.com/, Store Fluticasone inhaler in the unopened foil pouch and only open when ready for use. Safely throw away Fluticasone in the trash one month after it is opened or when the counter reads zero, whichever comes first. II. Facility policy and procedures The Storage of Medication policy, revised November 2020, was provided by the nursing home administrator (NHA) on 4/29/24 at 4:50 p.m. It revealed in pertinent part, The facility stores all drugs and biologics in a safe, secure and orderly manner. The nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Medications are stored separately from food and are labeled accordingly. III. Observations and staff interviews (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24 at 9:55 a.m., the 400 hall medication cart was observed with licensed practical nurse (LPN) #1. The following items were found: -One Fluticasone inhaler that did not have an open date. The medication's box indicated the medication needed to be disposed of one month after opening; and, -One Humalog insulin pen with no open date. LPN #1 was interviewed on 4/29/24 at 10:00 a.m. LPN #1 said insulin medications should be dated when opened to determine when it needed to be discarded LPN #1 said the medication's box indicated to discard the Fluticasone inhaler one month after opening. LPN #1 said the inhaler was not dated and unsure when it was opened. The 500 hall medication cart was reviewed on 4/29/24 at 10:05 a.m. with LPN #2. The following items were found: -One Humalog insulin pen that was dated with a date of opened 2/22/24; and, -One Lantus insulin pen with a date of opened 3/19/24. -The Humalog insulin pen should have been disposed of on 3/21/24 and the Lantus insulin pen should have been disposed of on 4/16/24. LPN #2 was interviewed on 4/29/24 at 10:10 a.m. LPN #2 said Humalog and Lantus insulin pens were good for 28 days after they were opened. LPN #2 said after 28 days, it was possible the medication would be dangerous to administer to a resident. He said open dates were important to know, as some medications were only good for a specific number of days. The director of nursing (DON) was interviewed on 4/30/24 at 2:10 p.m. The DON said medications such as insulin and inhalers should be labeled with the resident's name and the date it was opened. The DON said some medications were only good for a certain number of days after they were opened. She said the effects of the medication could decrease if it was administered after the date it should have been disposed of. The DON said she would provide education for the nursing staff right away.