STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065255	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Health Care Center	1440 Vine St Denver, CO 80206

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observation, record review, interview, and review of facility policy, the facility failed to ensure two residents (Resident (R)51 and R72) out two residents observed with catheter bags out of 20 sampled residents reviewed had dignity bags for their use of a foley catheter. This failure had the potential to cause embarrassment and loss of dignity to the two residents. Findings include: Review of the facility's policy, provided by the facility, titled Dignity with an issued date of 05/06/19 and reviewed on 09/25/23 revealed Each resident has the right to be treated with dignity and respect. The procedure was to promote resident independence and dignity while dining and refrain from practices demeaning to the resident, such as leaving urinary catheter bags uncovered. 1. Review of R51's Face Sheet located in the electronic medical record (EMR) under the Admission Record revealed R51 was admitted to the facility on [DATE]. Review of R51's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Admission Reference Date (ARD) of 04/03/23 revealed a Brief Interview of Mental Status (BIMS) score of three out of 15 which indicated severely impaired cognition. The MDS indicated R51 had an indwelling suprapubic catheter. During an observation on 10/01/24 at 10:19 AM revealed R51's foley catheter (indwelling urinary catheter) was attached to the bed frame on the side facing the door and there was a clear plastic bag over the catheter but you could still observe the bag and urine from the resident's doorway. 2. Review of R72's Face Sheet located in the EMR under the Admission tab revealed R72 was admitted to the facility on [DATE]. Review of R72's significant change MDS located in the EMR under the MDS tab with an ARD of 08/16/24 revealed a BIMS of zero out of 15 which indicated he was unable to complete the cognition assessment. The MDS revealed that R72 had an indwelling urinary catheter. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/24 at 12:01 PM Certified Nursing Assistant (CNA)1 confirmed the catheter bags were not covered yesterday or earlier today for R51 and R72. CNA1 stated they had the blue dignity bags today and she had placed them on R51's and 72's catheter bag. CNA1 stated the catheter bag should be covered for resident dignity and privacy. During an interview on 10/02/24 at 10:59 AM with Licensed Practical Nurse (LPN)1 revealed a catheter bag should be covered with a privacy bag to keep it private from others to maintain the dignity of a resident. LPN1 revealed there was a master key to the supply room, on the second floor, that staff had access to and could get a blue privacy bag anytime. During an interview with the Director of Nursing (DON) on 10/02/24 at 11:25 AM revealed catheter bags should be in a privacy bag to ensure the residents dignity. During an interview with the Administrator on 10/02/24 at 4:30 PM revealed the catheter bag should be covered with a dignity bag to ensure a resident maintained their dignity.

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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** 29015 Based on observation, interview, record review, and facility policy review, the facility failed to ensure four residents (Resident (R) 2, R6, R30, and R41) out of a total sample of 20 residents reviewed for respiratory services received appropriate care of their oxygen tubing. This created the potential for infection. Findings include: Review of the facility policy titled Oxygen Administration (Safety, Storage, and Maintenance), issued 12/03/18 and revised 02/27/24 and under the sub section titled Infection Control indicated .Change oxygen supplies weekly and when visibly soiled. Equipment should be labeled with patient name and dated when set-up or changed out . 1. Review of R2's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R2 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia and dependence on supplemental oxygen. Review of R2's Physician Orders located under the Orders tab of the EMR revealed an order for oxygen at three liters per minute (lpm), continuously, per nasal cannula and an order to change the oxygen tubing every night shift, on every Sunday. During an observation on 10/01/24 at 1:25 PM revealed R2's oxygen tubing had no date to indicate when the tubing change was last changed. 2. Review of R6's Admission Record, located under the Profile tab of the EMR, revealed R6 was admitted to the facility on [DATE] with a diagnosis of obstructive sleep apnea. Review of R6's Physician Orders located under the Orders tab revealed an order for the titration of oxygen to keep her pulse ox (measurement of the oxygen content of the blood) over 90%, the use of Bi-pap (breathing assistance via a mask and oxygen) at night, and an order to change the oxygen tubing every night shift on every Sunday. During an observation on 10/01/24 at 2:00 PM revealed R6 had her oxygen on and there was no date on the tubing to indicate when it had last been changed. 3. Review of R30's Admission Record, located under the EMR under the Profile tab, revealed R30 was admitted to the facility on [DATE]. Review of R30's Physician Orders revealed orders for oxygen at two liters continuously per nasal cannula and an order to change the oxygen tubing and nebulizer circuit every night shift on every Sunday as per the Physician order. During an observation on 09/30/24 at 2:46 PM and on 10/02/24 at 11:00 AM revealed R30's oxygen tubing was not dated to indicate when the last time it was changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of R41's Admission Record, located in the EMR under the Profile tab, revealed R41 was admitted to the facility on [DATE] with a diagnosis which included chronic obstructive pulmonary disease (COPD). Review of R41's Physician Orders revealed an order for oxygen at three liters/minute continuously per nasal cannula and an order to change the oxygen tubing and nebulizer circuit every night shift every Sunday. During an observation on 10/01/24 at 1:50 PM indicated R41's oxygen tubing was not dated to indicate the last time it had been changed. During an interview with the Unit Manager on 10/02/24 at 1:00 PM, the Unit Manager confirmed that the oxygen tubing for R2, R6, R30, and R41 had not been changed on the night shift on Sunday per physician's orders.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36246 Based on record review, interview, and review of facility policy, the facility failed to ensure weights were documented for one (Resident (R) 31) of two residents reviewed for dialysis out of a sample of 20 residents. This had the potential for the resident to have unmet care needs. Findings include: Review of the facility policy titled Hemodialysis Offsite Policy effective 04/24/19 and last reviewed 09/06/24 indicated that under the Procedure section revealed, the facility should weigh the resident. Under the Day of Dialysis section indicated, the facility should observe the vascular access site prior to dialysis and initiate the Pre/Post Dialysis Communication Form to be sent to the dialysis with the resident. The Day of Dialysis section indicated on return to the facility, facility staff should obtain vital signs and complete the Pre/Post Dialysis Communication Form. Review of R31's Admission Record, located in the EMR under the Profile tab, revealed R 31 was admitted to the facility on [DATE] with a diagnosis including, end stage renal disease (ESRD). Review of the Physician Order in R31's EMR revealed an order for R31 to have dialysis on Tuesdays, Thursdays, and Saturdays. Review of Pre/post Dialysis Communication Form located in the EMR under the Documents tab dated between 06/01/24 and 09/28/24 indicated R31's pre and post weights, which were to be done by the facility staff according to the Pre/post Dialysis Communication Forms, were not completed as follows: 06/01/24-pre and post weights 06/04/24-pre and post weights 06/06/24-pre weight 06/08/24-pre and post weights 06/11/24-pre and post weights 06/20/24-pre and post weights 06/22/24-pre and post weights 06/25/24-pre and post weights 06/27/24-post weight 07/02/24-pre weight 07/08/24- pre and post weight (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/11/24-pre and post weight 07/13/24-pre and post weight 07/18/24-pre and post weight 08/01/24-pre and post weight 08/03/24-pre and post weight 08/08/24-post weight 08/10/24-pre and post weight 08/13/24-pre and post weight 08/15/24-pre and post weight 08/17/24-pre and post weight 08/20/24-pre and post weight 08/22/24-pre and post weight 08/24/24-pre and post weight 08/31/24-pre and post weight 09/03/24-pre and post weight 09/05/24-pre and post weight 09/07/24-pre weight 09/10/24-pre and post weight 09/12/24-pre and post weight 09/14/24-pre weight 09/17/24-pre and post weight 09/21/24-pre and post weight 09/24/24-pre and post weight 09/26/24-pre and post weight (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/28/24-pre and post weight During an interview on 10/03/24 at 2:37 PM with the Minimum Data Set Coordinator (MDSC) and the Director of Nursing (DON) both confirmed the Pre/post Dialysis Communication Records, did not contain the pre and/or post weights as listed above for R31.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observation, record review, interview, and review of facility policy, the facility failed to ensure one resident (Resident (R)51) observed out of 20 sampled residents had their call light within reach. This failure had the potential to cause R51 needs to not be met . Findings include: Review of the facility's policy, provided by the facility, titled Keeping a Resident Room in Order, issued :08/09/2019 and reviewed 06/02/24 revealed The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely, call lights must be within easy reach of the resident in bed and out of bed. Review of R51's Face Sheet located in the electronic medical record (EMR) under the Admission Record revealed R51 was admitted to the facility on [DATE] with diagnoses of cognitive communication deficit, muscle weakness, need for assistance with care, and schizophrenia. Review of R51's annual Minimum Data Set (MDS) assessment located in the EMR under the MDS tab with an Admission Reference Date (ARD) of 04/03/23 revealed a Brief Interview of Mental Status (BIMS) score of three out of 15 which indicated severely impaired cognition Review of R51's comprehensive Care Plan with a target date of 10/20/24 located in the EMR under the Care Plan tab revealed a problem for ADL (activities of daily living) self-care deficit and one of the interventions was to encourage R51 to use the bell to call for assistance. Review of the problem for impulsiveness and impaired memory revealed an intervention was for the call light to be in reach. During an observation on 09/30/24 at 1:20 PM revealed R51's in bed with his eyes closed and the call light was hanging on the drawers beside his bed and not in his reach. During an observation on 10/02/24 at 3:17 PM revealed R51s was in bed with his eyes closed and his call light was on the floor behind the bed and not in the resident's reach. During an interview on 10/02/24 at 3:17 PM with Licensed Practical Nurse (LPN)1 she confirmed the call light was on the floor and not within R51's reach. LPN1 revealed the call light should have a clip on it so it can be clipped to the blanket, and it did not have a clip. LPN1 stated R51 was able to utilize the call light. During an interview on 10/02/24 at 4:30 PM with the Administrator revealed the call light should be in reach of the resident and not on the floor. During an interview on 10/03/24 at 1:10 PM with the DON revealed call lights should be in reach of the residents for safety. The DON further revealed the call light should have a clip on it so it can be clipped to the bed so it would not fall on the floor. The DON stated the resident needed to be able to use the call light if he needed help.