

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2024
NAME OF PROVIDER OR SUPPLIER  Highline Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  6060 E Iliff Ave Denver, CO 80222	
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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50315</p> <p>Based on observations, record review and interviews, the facility failed to maintain the emergency response carts and equipment in safe operating condition for five of five emergency response (crash) carts.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Ensure equipment was checked on a regular basis to ensure it was in proper working condition;</li> <li>-Ensure crash carts contained backboards and they were properly maintained and ready for use; and,</li> <li>-Ensure each crash cart contained a blood pressure cuff and stethoscope that was properly maintained and ready for use.</li> </ul> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Emergency Crash Cart and Automated External Defibrillators (AED) policy, undated, received from the nursing home administrator (NHA) on [DATE], documented in pertinent part, It is the policy of this facility to ensure that the facility will maintain at least one emergency cart per nursing care floor with additional carts added as deemed necessary in the case of the need for basic life support. In addition, the facility will ensure that at least one AED, if available, is for use in the case of cardiac emergencies. Equipment/supplies from the emergency crash cart are used only when emergency care is provided. Equipment/supplies used from the emergency crash cart are noted and replaced promptly. The emergency crash cart is checked every 24 hours and after every use. Missing or expired items are replaced, when applicable. AED use is authorized for personnel certified in CPR and use of the AED. The AED will be checked and the battery replaced according to manufacturer's recommendations. Follow manufacturer's instructions for correct usage of the AED. Clinical staff will be educated on the location and use of the emergency crash cart and AED. Nursing staff should be familiar with the contents located on and within the emergency crash cart.</p> <p>II. Observations and record review</p> <p>The crash cart on the Union hall was observed with the unit manager (UM) on [DATE] at 9:10 a.m. The following was observed:</p> <p>(continued on next page)</p>		

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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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The safety check log was only partially filled out and was missing several checks from the month of [DATE]. There were 17 of a possible total of 23 dates missing safety checks.</p> <p>The crash cart on the Capital Hill hall was observed with the UM on [DATE] at 9:13 a.m. The following was observed:</p> <ul style="list-style-type: none"> <li>-There was no backboard present.</li> </ul> <p>-The safety check log was incomplete and there were no dates from [DATE] checked.</p> <p>The crash cart in the dining room was observed with the UM on [DATE] at 9:15 a.m. The following was observed:</p> <ul style="list-style-type: none"> <li>-The safety check log was incomplete and there were no dates from [DATE] checked.</li> </ul> <p>The crash cart on the Seasons hall was observed with the UM on [DATE] at 9:20 a.m. The following was observed:</p> <ul style="list-style-type: none"> <li>-There was no backboard present.</li> <li>-The safety check log was incomplete and there were no dates from [DATE] checked.</li> </ul> <p>The crash cart on the Cherry Creek hall was observed with the UM on [DATE] at 9:23 a.m. The following was observed:</p> <ul style="list-style-type: none"> <li>-There was no backboard present.</li> <li>-There was no blood pressure cuff or stethoscope on the cart.</li> <li>-There was no safety check log present.</li> </ul> <p>III. Staff interviews</p> <p>The UM was interviewed on [DATE] at 9:00 a.m. The UM said the facility did not have a defibrillator (machine used for someone in cardiac arrest). She said it was the night shift nurses responsibility to complete the safety check logs on each crash cart. She said the safety check logs prompted the nurses to check for expired, missing, or malfunctioning equipment. She said monitoring of the crash cart should be completed once every 24 hours. She said nursing management audited the safety logs periodically.</p> <p>The director of nursing (DON) was interviewed on [DATE] at 10:30 a.m. The DON said it was the responsibility of the night shift nursing staff to check the crash carts and complete the logs. He said crash carts were expected to be checked each night and the logs were to be filled out with each check. He said this had not been happening because of the inconsistency of the night shift nurses. He said there were many agency staff nurses who did not know the process or expectation of completing a crash cart safety check. He said nursing management currently did not audit the safety logs. He said there should be a backboard for each crash cart.</p>		