

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/26/2026
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Pueblo		STREET ADDRESS, CITY, STATE, ZIP CODE  2118 Chatalet LN Pueblo, CO 81005	
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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazardous situations for one (#1) of three residents reviewed for accident hazards out of 19 sample residents. Resident #1 was admitted to the facility on [DATE]. Resident #1's comprehensive care plan revealed the resident was taking an anticoagulant (blood thinner) medication and goals included preventing abnormal bleeding and bruising as a result. On 12/24/25 at approximately 2:40 p.m. Resident #1 was being assisted to an activity in the dining room by the social services director (SSD) in her wheelchair without the foot pedals in place. Resident #1's left leg was bumped on her wheelchair when her leg dropped. At 5:41 p.m. Resident #1 complained of pain to her lower left leg. At 8:52 p.m. Resident #1 was found to have a large hematoma (a closed wound where blood collects and fills a space inside the body) on her left calf which measured 8 inches by 4 inches. Resident #1's physician was contacted and new physician's orders were received to hold the resident's anticoagulant medication and elevate the leg and ice as tolerated. Resident #1 was sent out to the emergency room on [DATE] and was treated with a splint, as-needed pain medication and orders to ice the hematoma as tolerated, and discharged back to the facility on [DATE]. After the incident with Resident #1 on 12/24/25, education was provided to staff regarding the importance of transporting residents in their wheelchairs with foot pedals in place. However, observations during the survey (from 2/25/26 to 2/26/26) revealed staff continued to transport residents in their wheelchairs without foot pedals in place. Specifically, the facility failed to ensure staff transported Resident #1, who was on anticoagulant medication, in her wheelchair with the foot pedals in place, which resulted in a significant hematoma to the calf of the resident's left leg, causing the resident pain and requiring a trip to the emergency room for the resident. Findings include: I. Resident #1A. Resident status Resident #1, age [AGE], was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included cognitive communication deficit, history of falling, unsteadiness on feet, atrial fibrillation and personal history of transient ischemic attack (stroke). The 11/20/25 minimum data assessment (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. The resident was independent for most activities of daily living (ADL). The assessment documented the resident used a wheelchair for mobility. The assessment documented the resident received an anticoagulant medication. B. Record review The anticoagulant medication care plan, revised 12/26/24, revealed Resident #1 was receiving anticoagulant therapy. The goal of the care plan was to minimize abnormal bleeding and bruising for Resident #1. Pertinent interventions included administering anticoagulant medications as ordered and assessing Resident #1 for side effects, including muscle or joint pain and bruising each shift. The skin integrity care plan, revised 5/2/23, revealed Resident #1 was at risk for breaks in skin integrity due to her fragile skin, decreased mobility,</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, record review and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease. Specifically, the facility failed to:-Ensure staff performed appropriate hand hygiene when handling residents' meal trays and water pitchers;-Ensure staff handled residents' drinkware and silverware in a sanitary manner; and,-Ensure staff donned (put on) face masks appropriately during a facility outbreak with COVID-19. Findings include: I. Failed to ensure staff performed appropriate hand hygiene when handling residents' meal trays and water pitchers A. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 3/3/26 from <a href="https://www.cdc.gov/cleanhands/hcp/clinical-safety/index.html">https://www.cdc.gov/cleanhands/hcp/clinical-safety/index.html</a>, included the following recommendations for hand hygiene, Hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of germs, including those resistant to antibiotics. Clean your hands immediately before touching a patient and after touching a patient or the patient's surroundings. B. Facility policy and procedure The Resident Dining Services policy and procedure, revised 4/29/25, was provided by the nursing home administrator (NHA) on 2/26/26 at 1:17 p.m. It read in pertinent part, Staff involved in dining/food services will perform hand hygiene prior to distributing trays to the residents and when serving food to residents. C. Observations On 2/25/26 at 12:07 p.m. certified nurse aide (CNA) #4 was going from room to room collecting residents' water pitchers, refilling them with ice water and returning the pitchers to the residents' rooms. CNA #4 entered an unidentified resident's room, collected her water pitcher and brought it to the resident to encourage her to drink. CNA #4 held the resident's straw with his bare hand so the resident could sip from the water pitcher. CNA #4 then returned the resident's water pitcher to her room, and continued going from room to room down the hallway refilling water pitchers. -CNA #4 did not perform hand hygiene between each resident's room or after handling the resident's straw. At 1:00 p.m. CNA #5 was assisting an unidentified resident in the dining room with putting her shirt back on. CNA #5 then went to look for the resident's lunch tray and moved several other residents' trays before finding the tray that belonged to the resident. CNA #5 assisted the resident with putting her shirt on again and oriented the resident to her meal tray. CNA #5 then continued passing out meal trays to other residents in the dining room. -However, CNA #5 did not perform hand hygiene after assisting the resident with putting her shirt on or between each resident's meal tray. At 1:09 p.m. CNA #5 entered an unidentified resident's room to deliver her room tray. CNA #5 oriented the resident to her meal tray and began to assist the resident with cutting up her food. CNA #5 then left the resident's room, grabbed another room tray and entered another resident's room. -However, CNA #5 did not perform hand hygiene between each resident when assisting with meal delivery. D. Staff interviews The infection preventionist (IP) was interviewed on 2/26/26 at 11:18 a.m. The IP said staff members should perform hand hygiene before handling room trays and after leaving residents' rooms, especially if they assisted the residents with handling their food or opening packets. The director of nursing (DON) was interviewed on 2/26/26 at 11:32 a.m. The DON said staff members should perform hand hygiene between each tray when delivering meal trays. The DON said the facility had identified concerns in this area and had been doing audits of meal hand hygiene a few months ago. The DON said the facility had provided education to the nursing and dietary staff at the time the concerns were identified, and put signs on the meal delivery carts as a reminder to perform hand hygiene. The DON said the facility's administration staff still saw occasional issues with hand hygiene during meals, but said the audits had decreased the rate of issues significantly. -However, observations conducted during the</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>survey process revealed concerns with staff performing hand hygiene between tray deliveries and in filling water pitchers (see observations above).II. Failed to ensure staff handled residents' drinkware and silverware in a sanitary mannerA. ObservationsOn 2/25/26 at 12:07 p.m. CNA #4 was going from room to room collecting residents' water pitchers, refilling them with ice water, and returning the pitcher to the residents' rooms. CNA #4 entered an unidentified resident's room, collected her water pitcher and brought it to the resident to encourage her to drink. CNA #4 grabbed the outside of his mask and pulled his mask down to speak with the resident. Using the same bare hand, CNA #4 held the resident's straw so she could sip from the water pitcher. CNA #4 then returned the resident's water pitcher to her room, and continued going from room to room down the hallway refilling water pitchers. -CNA #4 did not perform hand hygiene before or after handling the resident's straw or after handling his mask.On 2/26/26 at 9:13 a.m. CNA #3 began assisting an unidentified resident with eating breakfast. CNA #3 unwrapped the napkin around the resident's silverware and held her fork and knife by the cutting surface and tines. CNA #3 grabbed the resident's coffee mug by the rim of the mug and handed it to her. CNA #3 then began cutting up the resident's food.At 9:16 a.m. CNA #3 grabbed the unidentified resident's mug by the rim and pulled it closer to himself to add a packet of sugar to her coffee. CNA #3 then used the handle of the resident's knife to stir her coffee. CNA #3 had previously used the knife to cut the resident's food.B. Staff interviewsThe IP was interviewed on 2/26/26 at 11:18 a.m. The IP said staff members should not touch the area on silverware where a resident's mouth would go. The IP said staff members should not grab mugs or cups by the top, and said it was not okay to grab areas where the resident's mouth would then touch.The DON was interviewed on 2/26/26 at 11:32 a.m. The DON said staff should not handle the rims of residents' cups or the end of the residents' silverware that the resident would then put into their mouth.III. Failed to ensure staff donned face masks appropriately during a facility outbreakA. Facility policy and procedureThe Universal Source Control policy and procedure, revised 7/7/25, was received from the NHA on 2/26/26 at 1:17 p.m. It read in pertinent part, Source control is the use of respirators or well-fitting face masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing or coughing. Source control is recommended for individuals in healthcare settings who reside or work on an area of the facility experiencing an outbreak of respiratory infection. Healthcare professionals should be instructed that if they must touch or adjust their facemask they should perform hand hygiene immediately before and after.B. ObservationsOn 2/25/26 at 12:07 p.m. CNA #4 entered an unidentified resident's room, collected her water pitcher and brought it to the resident to encourage her to drink. CNA #4 grabbed the outside of his mask and pulled his mask down to speak with the resident. CNA #4 bent down and put his face beside the resident's ear while doing so. After speaking with her, CNA #4 pulled his mask back up and encouraged the resident to drink. CNA #4 repeated this process moments later.-CNA #4 did not perform hand hygiene after handling his mask, and his mask did not cover his mouth and nose while in close contact with the resident.On 2/26/26 at 9:09 a.m. CNA #3 was in the dining room assisting residents with getting to their seats for the breakfast meal service. CNA #3 was wearing a surgical mask which was pulled down below his mouth.At 9:13 a.m. CNA #3 sat next to an unidentified resident and began assisting her with eating. CNA #3 continued to wear his surgical mask under his mouth.C. Staff interviewsThe IP was interviewed on 2/26/26 at 11:18 a.m. The IP said the facility was in outbreak status at the moment for COVID-19, but did not have any current cases of COVID-19 in the resident population. The IP said their most recent positive case was a staff member who had tested positive for COVID-19 the week prior (week of 2/16/26). The IP said the facility's last day of outbreak status would be on 2/28/26. The IP said he had been</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/26/2026
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Pueblo		STREET ADDRESS, CITY, STATE, ZIP CODE  2118 Chatalet LN Pueblo, CO 81005	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>enforcing surgical mask use for staff members, especially when they were in resident care areas. The IP said staff should wear their masks so they covered both their nose and their mouth. The IP said he had to provide spot-education to a few employees the day prior (2/25/26) to ensure their noses were covered by their masks. The IP said staff members should perform hand hygiene after handling the outside of their mask, as the mask was technically considered to be a contaminated surface. The DON was interviewed on 2/26/26 at 11:32 a.m. The DON said staff members should be wearing face masks in the facility hallways and resident care areas during the facility's COVID-19 outbreak. The DON said staff members' masks should cover both their nose and their mouth. The DON said if a resident was having difficulty communicating and the staff member needed to lower their mask to communicate with them, the staff member should avoid pulling their mask down in a hallway. The DON said the staff member should try to bring the resident to a room or office to facilitate communication.</p>		