STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065269	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Pueblo	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 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50219

Based on record review and interviews, the facility failed to develop a comprehensive care plan for services that were to be provided in order to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for two (#63 and #6) of five residents reviewed for care planning out of 36 sample residents.

Specifically, the facility failed to:

-Develop a dementia care plan focus for Resident #63 and Resident #6; and,

-Update care plan interventions for falls for Resident #63.

Findings include:

I. Facility policy

The Incident and Reportable Event Management policy, revised 8/15/23, was provided by the nursing home administrator (NHA) on 5/8/24 at 8:12 a.m. It read in pertinent part, The licensed nurse should update the resident's care plan and communicate the intervention to the staff caring for the resident.

The Care of the Cognitively Impaired (Dementia Care) policy, revised 8/22/23, was provided by the NHA on 5/8/24 at 8:12 a.m. It read in pertinent part, Develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment.

Develop individualized interventions related to the resident's symptomology and rate of progression.

Review and revise care plans that have not been effective and/or when the resident has a change in condition.

II. Resident #63

A. Resident status

(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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #63, age greater than 65, was admitted [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dementia and insomnia. The 2/15/24 minimum data assessment (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required moderate to maximal assistance with transfers. B. Record review The care plan, initiated 12/7/23 and revised 4/26/24, revealed Resident #63 was at risk for elopement. Pertinent interventions included providing one on one supervision while the resident was out of bed and assessing for fall risk. The fall care plan, initiated 11/10/23 and revised 11/21/23, revealed Resident #63 was at risk for falls due to decreased mobility, weakness, cognitive impairment and poor safety awareness. Pertinent interventions included ensuring the resident wore appropriate footwear, having the call light within reach and completing a fall risk assessment. -The care plan did not include any focus areas for dementia or cognitive decline. -The care plan focus area for falls had not been updated after any of Resident #63's falls in 2024. A progress note on 12/16/23 at 11:30 p.m. revealed Resident #63 was found sitting on the floor on his floor mat. A progress note on 2/28/24 at 8:30 p.m. revealed Resident #63 was found sitting on the floor next to his bed. The note revealed Resident #63 had a floor mat in place but that the resident often moved the mat away from his bedside. A progress note on 4/29/24 at 1:39 p.m. revealed Resident #63 was found sitting on the floor mat next to his bed. The 12/16/23 fall investigation report revealed Resident #63 had an unwitnessed fall and was found on the floor next to his bed. Frequent checks every fifteen minutes were put in place as a new intervention per the report. The 2/26/24 fall investigation report revealed Resident #63 had an unwitnessed fall and was found on the floor next to his bed. No new interventions were written in the report. The 4/3/24 fall investigation report revealed Resident #63 had an unwitnessed fall and was found on the floor next to his bed. No new interventions were written in the report. The 4/29/24 fall investigation report revealed Resident #63 had an unwitnessed fall and was found on the floor next to his bed. Bed in lowest position was documented as a new intervention but was scratched out. -However, the intervention had not been updated on the resident's care plan (see care plan above). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/20/24 care plan conference notes revealed Resident #63's care plan was reviewed but no changes were noted at that time. C. Staff interviews Certified nursing assistant (CNA) #6 was interviewed on 5/9/24 at 9:01 a.m. CNA #6 said Resident #63 needed to be in a bed at the lowest position and she was not sure whether the resident needed a fall mat. CNA #6 said the interventions should have been in Resident #63's care plan, along with dementia care and its pertinent interventions. Licensed practical nurse (LPN) #2 was interviewed on 5/9/24 at 9:11 a.m. LPN #2 said Resident #63 needed to have his bed in the lowest position, have his wheelchair and walker away from the bed to avoid self-transfers and have a fall mat in place. LPN #2 said the interventions were in Resident #63's care plan. LPN #2 said Resident #63 had not fallen for some time, so the new interventions were effective. LPN #2 said dementia care was a separate area with its own interventions, and the DON and nursing managers updated the care plans. -However, the interventions mentioned by LPN #2 were not on the care plan (see care plan above). The director of nursing (DON) and assistant director of nursing (ADON) were interviewed together on 5/9/24 at 9:34 a.m. The DON said Resident #63 had interventions to prevent falls, including having his bed in the lowest position, fall mat in place and having non-skid footwear. The DON said Resident #63's care plan was updated as needed and reviewed quarterly and the nursing staff could update it if needed. The DON said care plans specifically for cognitive impairment due to dementia were created and managed by the social services department. The ADON said the facility staff met after fall incidents to talk about new interventions, and discussed these interventions during rounds. -The ADON reviewed the care planned interventions for Resident #63's falls and said the interventions of the bed in lowest position and fall mat in place were not on the care plan. The social services assistant (SSA) and social services director (SSD) were interviewed on 5/9/24 at 9:58 a. m. The SSA said for residents with dementia diagnoses, their care plans usually had a specific focus indicating they had impaired cognition due to dementia and pertinent and person-centered interventions. The SSA said care plans were reviewed quarterly, yearly and as needed. The SSA could not identify any specific focus on Resident #63's care plan related to cognitive impairment. The SSD said Resident #63's care plan was different, and that she did not see anything specifically related to his dementia diagnosis. III. Resident #6 A. Resident status (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6, age 77, was admitted [DATE]. According to the May 2024 CPO, diagnoses included dementia and neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function). The 2/13/24 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of 11 out of 15. B. Record review The 5/4/23 care plan revealed Resident #6 had a behavior problem and was taking a psychotropic medication for behaviors with dementia. Pertinent interventions included administering medications as ordered and anticipating and meeting the resident's needs. The 5/18/23 care plan revealed Resident #6 was using a psychotropic medication to treat dementia with behaviors. Pertinent interventions included administering medications and observing for side effects and effectiveness and consulting with the pharmacists to consider a dosage reduction when clinically appropriate. -The care plan did not include any focus areas for dementia or cognitive decline. C. Staff interviews The SSD was interviewed on 5/9/24 at 9:58 a.m. The SSD said she could not find any focus in Resident #6's care plan specifically for dementia. The SSD read aloud the care plan focus for Resident #6 that was related to the resident being on psychotropic medications and pointed out that it said the resident was on the medication related to dementia with behaviors. -However, the care plan did not include a specific focus for dementia and pertinent behaviors to address the resident's dementia and behaviors related to dementia.

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 31820 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for five of five staff reviewed. Specifically, the facility had not completed annual performance reviews and/or provided regular in-service education based on the outcome of the reviews for certified nurse aide (CNA) #1, CNA #2, CNA #3, CNA #4 and CNA #5. Findings include: I. Record review CNA #1 (hired on 9/5/15), CNA #2 (hired on 2/20/2020), CNA #3 (hired on 8/25/2020), CNA #4 (hired on 5/24/2020) and CNA #5 (hired on 9/20/22) did not have an annual performance review completed. The CNAs did not have an in-service education plan based on the outcome of the review. II. Interview The director of nursing (DON) was interviewed on 5/7/24 at 4:00 p.m. The DON said she was not aware the performance reviews needed to include a regular in-service plan based on the outcome of these reviews. She said going forward she would ensure the performance reviews were completed annually to ensure the best care was being delivered to the residents.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31820

Based on observations, interviews and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with accepted professional standards for two of three medication carts.

Specifically, the facility failed to ensure inhalers were dated when opened.

Findings include:

I. Professional reference

According to the Incruse inhaler manufacturer's guidelines, retrieved on [DATE] from https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Incruse_Ellipta/pdf/INCRUSE-ELLIPTA-PI-PIL-IFU.PDF, Discard Incruse six weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first.

According to the Wixela inhaler manufacturer's guidelines, retrieved on [DATE] from https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=3beef,d+[DATE]a,d+[DATE]a,d+[DATE]ba,d+[DATE]e4b7e2, Discard Wixela Inhub one month after opening the foil pouch or when the counter reads 0 (after all doses have been used), whichever comes first.

According to the Trelegy inhaler manufacturer's guidelines, retrieved on [DATE] from https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Trelegy_Ellipta/pdf/TRELEGY-ELLIPTA-PI-PIL-IFU.PDF, Discard Trelegy six weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first.

II. Observations and interviews

On [DATE] at 8:45 a.m. the H hall medication cart was observed with registered nurse (RN) #1.

The medication cart contained a Trelegy inhaler.

-The inhaler was not dated with the date it was opened.

RN #2 said she did not know the Trelegy inhaler was expired. She said the inhaler should have been dated to ensure safety of the medication and to know when to discard the inhaler.

On [DATE] at 8:55 a.m. the G hall medication cart was observed with licensed practical nurse (LPN) #1. The medication cart contained an open Incruse inhaler and Wixela inhaler.

-Both inhalers were not dated when opened.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 said she was not aware the inhalers did not have an open date. She said it was important to date the inhalers when they were opened to make sure it was safe to administer the medication to the resident. III. Additional interview The director of nursing (DON) was interviewed on [DATE] at 11:00 a.m. The DON said it was important for all medications to be dated when opened and discarded when expired to ensure the medication was safe for the residents who received them.